

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 9 7 2

REG. NO.

|   |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | 2a. DATE OF DEATH  |  |  | MONTH  |  |  | DAY   |  |  | YEAR   |  |  | 2b. HOUR                                     |  |  |
| RICHARD G. HADDAWAY   |  |  | 1  |  |  | 23   |  |  | 83  |  |  | 4:10P M  |  |  |  |  |  |
| 3. SEX  |  |  | 4. RACE  |  |  | 5. DATE OF BIRTH   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |  | 7. IF UNDER 1 YEAR   |  |  | 8. IF UNDER 24 HRS.                          |  |  |
| Male  |  |  | White  |  |  | JULY 3, 1925   |  |  | 57  |  |  | MONTHS   |  |  | DAYS   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |  |  |  |  |  |
| Maryland  |  |  | U.S.A.   |  |  |  |  |  | Baltimore City,   |  |  |  |  |  | MD.  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |  |  |  |  |  |
| Baltimore   |  |  | VAMC, BALTIMORE, MARYLAND 21218  |  |  | Disabled   |  |  |   |  |  |  |  |  |  |  |  |
| 13a. STATE  |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN  |  |  | 13d. INSIDE CITY LIMITS?  |  |  | 13e. STREET ADDRESS  |  |  | 21239  |  |  |
| Maryland  |  |  | Baltimore  |  |  | Baltimore  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 6908 Lachlan Circle Apt. E                                     |  |  |  |  |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |   |  |  |  |  |  |  |  |  |
| FIRST MIDDLE LAST   |  |  | FIRST MIDDLE LAST  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |
| Reese L. Haddaway   |  |  | Elizabeth L. Freeman   |  |  |  |  |  |   |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)  |  |  | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT  |  |  | ADDRESS   |  |  |  |  |  |  |  |  |
| Yes   |  |  | WW II  |  |  | 220-12-6505  |  |  | Mr. Reese T. Haddaway   |  |  | 3529 Woodring Ave.   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |
| 2028 IMMEDIATE CAUSE (a) Sepsis   |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |
| (b) Complications of Chemotherapy   |  |  |  |  |  |  |  |  |   |  |  |  |  |  | 2 wks  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |
| (c) Symphoma  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |
| Pulmonary Fibrosis from chemotherapy  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  |  | 20a. AUTOPSY?   |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)   |  |  |   |  |  |  |  |  |  |  |  |
|   |  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |  |  |   |  |  |  |  |  |  |  |  |
|   |  |  | P.M. 19  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED  |  |  | 21e. PLACE OF INJURY   |  |  | 21f. LOCATION  |  |  |   |  |  |  |  |  |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]   |  |  | STREET   |  |  | CITY OR TOWN  |  |  | COUNTY   |  |  | STATE  |  |  |
| 22a. I certify that X (this hospital) attended the deceased from DECEMBER 4, 1982, to JANUARY 23, 1983, that X (we) last saw the deceased alive on JANUARY 23, 1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. X (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  | DEGREE   |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  |  | 22c. DATE SIGNED  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  | 22e. ADDRESS   |  |  |  |  |  |   |  |  |  |  |  |  |  |  |
| MAURER MD   |  |  | VAMC, BALTIMORE, MARYLAND  |  |  | 21218  |  |  |   |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  | 23d. LOCATION   |  |  |  |  |  |  |  |  |
| Burial  |  |  | 1-27-83  |  |  | Woodlawn   |  |  | Baltimore, Maryland   |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |   |  |  |  |  |  |  |  |  |
| Leonard J. Ruck, Inc.   |  |  | Baltimore, Md.   |  |  | JAN 24 1983  |  |  | John J. Grier   |  |  |  |  |  |  |  |  |

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State of California  
County of Los Angeles  
City of Los Angeles  
I, the undersigned, being a duly qualified and authorized officer of the State of California, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of the State of California.



RECEIVED  
JAN 11 1933



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 771 death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

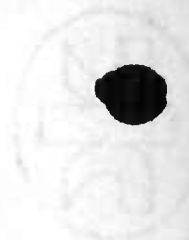
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a



## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   | 8 3 0 0 9 7 3   |  | REG. NO.                     |  |   |
|---|--|---|--|---|---|--|------------------------------|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>FREDERICK C. HAFNER</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 / 21 / 83</b>               |  | 2b. HOUR<br><b>1:00 P.M.</b> |  |   |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 19 26</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b> YRS.  |                              | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |                              |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>supervisor</b>  |                              | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>electric</b>   |   |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Arbutus</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                              | 13e. STREET ADDRESS<br><b>1242 Stevens Avenue 21227</b>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Albert L. Hafner</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie E. Fowler</b> |  |                              |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br><b>MM2 216-20-3248</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Kathryn Hafner 1242 Stevens Avenue</b>  |   |  |                              |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4275 IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                    |  |   |  |   |   |  |                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 MINUTE</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>CHRONIC RENAL FAILURE</b>  |  |   |  |   |   |  |                              |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>  |                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |                              |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)   |  | 21f. LOCATION<br>STREET<br><b>22 SOUTH GREENE ST. BALT. MD 21208</b>  |   | CITY OR TOWN   |                              | COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/21</b> , 19 <b>83</b> , to <b>1/21</b> , 19 <b>83</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/21/83</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |  |                              |  |   |
| 22b. SIGNATURE<br><b>JMW</b>  |  |   |  | DEGREE<br><b>MD</b>   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                              | 22c. DATE SIGNED<br><b>1/21/83</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WOGAN</b>   |  |   |  | 22e. ADDRESS<br><b>22 SOUTH GREENE ST. BALT. MD 21208</b>   |   |  |                              |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>burial</b>   |  | 23b. DATE<br><b>1/25/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore City Maryland</b>   |                              |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ambrose Funeral Home</b>   |  |   |  | ADDRESS<br><b>1328 Sulphur Spring Rd.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 24 1983</b>  |                              | 25b. REGISTRAR'S SIGNATURE<br><b>Joan J. Gair</b>  |   |

BP



Handwritten text at the bottom left, possibly a signature or date, including the word "JANUARY".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 9 7 4

REG. NO.

|   |   |   |  |  |                                    |  |  |  |
|---|---|---|--|--|------------------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   |   | 2a. DATE OF DEATH  |  |                                    | 2b. HOUR   |  |  |
| JERRY THORNTON HALE   |   |   | January 26, 1983   |  |                                    | 5:00P M  |  |  |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |                                    | 7. IF UNDER 1 YEAR   |  |  |
| Male  | White   | 08 14 11  | 71 YRS.  |  |                                    | MONTHS DAYS HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                   |  |                                    |  |  |  |
| Virginia  | U.S.A.  |   | Baltimore City MD.   |  |                                    |  |  |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)       |  |                                    | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| Baltimore   | Maryland General Hospital   |   | Riveter  |  |                                    | Steel Co.  |  |  |
| 13a. STATE  |   |   | 13b. COUNTY  |  |                                    | 13c. CITY OR TOWN  |  |  |
| Maryland  |   |   | ---  |  |                                    | Baltimore  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                          |  |                                    |  |  |  |
| James M. Hale   |   |   | Lena Sears   |  |                                    |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |   |   | 16b. SOCIAL SECURITY NO.   |  |                                    | 17. INFORMANT ADDRESS  |  |  |
| No  |   |   | 229-05-8735  |  |                                    | Allen DeShon 1001 Franklin Road 24016 Roanoke, Virginia  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:  |   |   |  |  |                                    |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                |
| IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>   |   |   |  |  |                                    |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |   |   |  |  |                                    |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |   |   |  |  |                                    |  |  |  |
| (b) <u>Gastrointestinal Bleeding</u>  |   |   |  |  |                                    |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |   |   |  |  |                                    |  |  |  |
| (c)   |   |   |  |  |                                    |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |  |  |                                    |  |  |  |
| <u>Severe Peripheral Vascular Disease</u>   |   |   |  |  |                                    |  |  |  |
| 19a. DATE OF OPERATION  |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |                                    | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| January 16, 1983  |   |   | Acute Occlusion of left Iliac Artery                                   |  |                                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR                        |  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |
|   |   |   | P.M. 19  |  |                                    |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |
|   |   |   |  |  |                                    |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>January 12, 1983</u> to <u>January 26, 1983</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>January 26, 1983</u> , and that in my <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |   |   |  |  |                                    |  |  |  |
| 22b. SIGNATURE<br><u>William Polito, M.D.</u>   |   |   |  |  |                                    | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>1/26/83                                    |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>William Polito, M.D.   |   |   |  |  |                                    | 22e. ADDRESS<br>C/O Maryland General Hospital  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |   |   | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |
| Removal/Burial  |   |   | 01-29-83   |  | Church Hill                        |  | Salem Roanoke Va.                          |  |
| 24. FUNERAL DIRECTOR<br>NAME  |   |   | 24b. ADDRESS   |  |                                    | 25a. DATE REC'D. BY REGISTRAR  |  |  |
| Balto., Md.   |   |   | 21229  |  |                                    | JAN 28 1983  |  |  |
| Hubbard Funeral Home, Inc.  |   |   | 4107 Wilkens Ave.  |  |                                    | REGISTRAR'S SIGNATURE<br><u>John J. Cawley</u>   |  |  |

BP 25



NO

PHENIX

JAN 2 1962

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8300975

FOR  
1- STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |  |  |  |  |  |
|--|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Agnes</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 23 83</b> |   |  | 2b. HOUR<br><b>7<sup>05</sup> A.M.</b>   |  |  |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>Black</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>03 21 16</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.                                    |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHN DEATON MED. CENTER</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. CITY OR TOWN<br><b>ANNAPOLIS</b>   |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS<br><b>26 Parole Street</b> <b>21401</b>                          |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CLINTON TONGUE</b>  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>AGNES BRANDFORD</b>   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>219-22-0750</b>  |   | 17. INFORMANT ADDRESS<br><b>EDWARD HALL 26 Parole St. Annapolis, Md. 21401</b>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4360</b> IMMEDIATE CAUSE (a) <b>CVA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>20 months</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <b>1/22 1983</b> to <b>1/22 1983</b> , that (we) last saw the deceased alive on <b>1/22 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did) (did not) view the body after death.                          |  |   |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>JA Gladen, MD</b>   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br><b>1/28/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |   | 22e. ADDRESS  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>1-31-1983</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Veterans Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crownsville A.A. Maryland</b>       |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b>   |  |   |   | 24a. ADDRESS<br><b>Annapolis, Md. 21401</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 26 1983</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called on.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 3 0 0 9 7 6   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ALICE BERTHA HALL   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 26 83  |  | 2b. HOUR<br>1:00AM   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 23 04   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2504 Roslyn Avenue |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>School Teacher   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>Public Sch.   |  |   |  |   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br>Maryland   |  |   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13e. STREET ADDRESS<br>2504 Roslyn Ave.-#21216   |  |   |  |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Wilson   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Mason   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>217-20-0334   |  | 17. INFORMANT<br>ADDRESS<br>2504 Roslyn Avenue<br>Vernon M. Hall-Baltimore, MD 21216  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>1561 IMMEDIATE CAUSE (a) Cancer B-1e ducts<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Months |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from June 19 77, to Jan 26 19 83, that (I) (we) last saw the deceased alive on Jan 23 19 83, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) show the body after death.   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>David I. Miller  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>1-28-83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DAVID I. MILLER   |  |   |  | 22e. ADDRESS<br>10219 S. DOLFIELD ROAD, BALT., MD 21216   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>1/31/83  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Park   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co., Md.   |  |
| 24. FUNERAL DIRECTOR<br>NUTTER FUNERALHOME 3035 W. NORTH AVE.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 28 1983  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Connelley  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 83 00977  |  |   |   |
|--|--|---|--|--|--|---|---|
| 1. FOR STATE REGISTRAR   |  |   |  |  |  |   |   |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>TRACY L. HALL</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1 12 83</b>   |  | 2b. HOUR<br><b>10 A M</b>   |   |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>4 2 99</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>83</b> YRS   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Michigan</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                  |  |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>424 E. Lake Ave.</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>                  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |  | 13d. STREET ADDRESS<br><b>424 E. Lake Ave. 21212</b>  |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Lake</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Unk.</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>215 44 0410</b>  |  | 17. INFORMANT ADDRESS<br><b>Mr. Michael P. Donnelly 10 Light St.</b>                               |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b><br><b>4029</b><br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>35 YRS</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>DIABETES MELLITUS TYPE II</b>  |  |   |  |  |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                     |  |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> 19 <b>47</b> to <b>JAN 12</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>Nov 29</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.            |  |   |  |  |  |   |   |
| 22b. SIGNATURE<br><b>Frederick J. Vollmer MD</b>   |  |   |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>1-12-83</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>FREDERICK J VOLLMER MD</b>   |  |   |  | 22e. ADDRESS<br><b>6100 YORK RD BALTIMORE, MD 21212</b>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>1/15/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount Cem.</b>                                      |  | 23d. LOCATION<br><b>Baltimore, Md.</b> COUNTY STATE   |   |
| 24. FUNERAL DIRECTOR NAME<br><b>MITCHELL-WIEDEFELD HOME, INC.</b> ADDRESS<br><b>6500 York Rd.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 19 1983</b> REGISTRAR'S SIGNATURE<br><b>John J. Connel</b> |  |   |   |

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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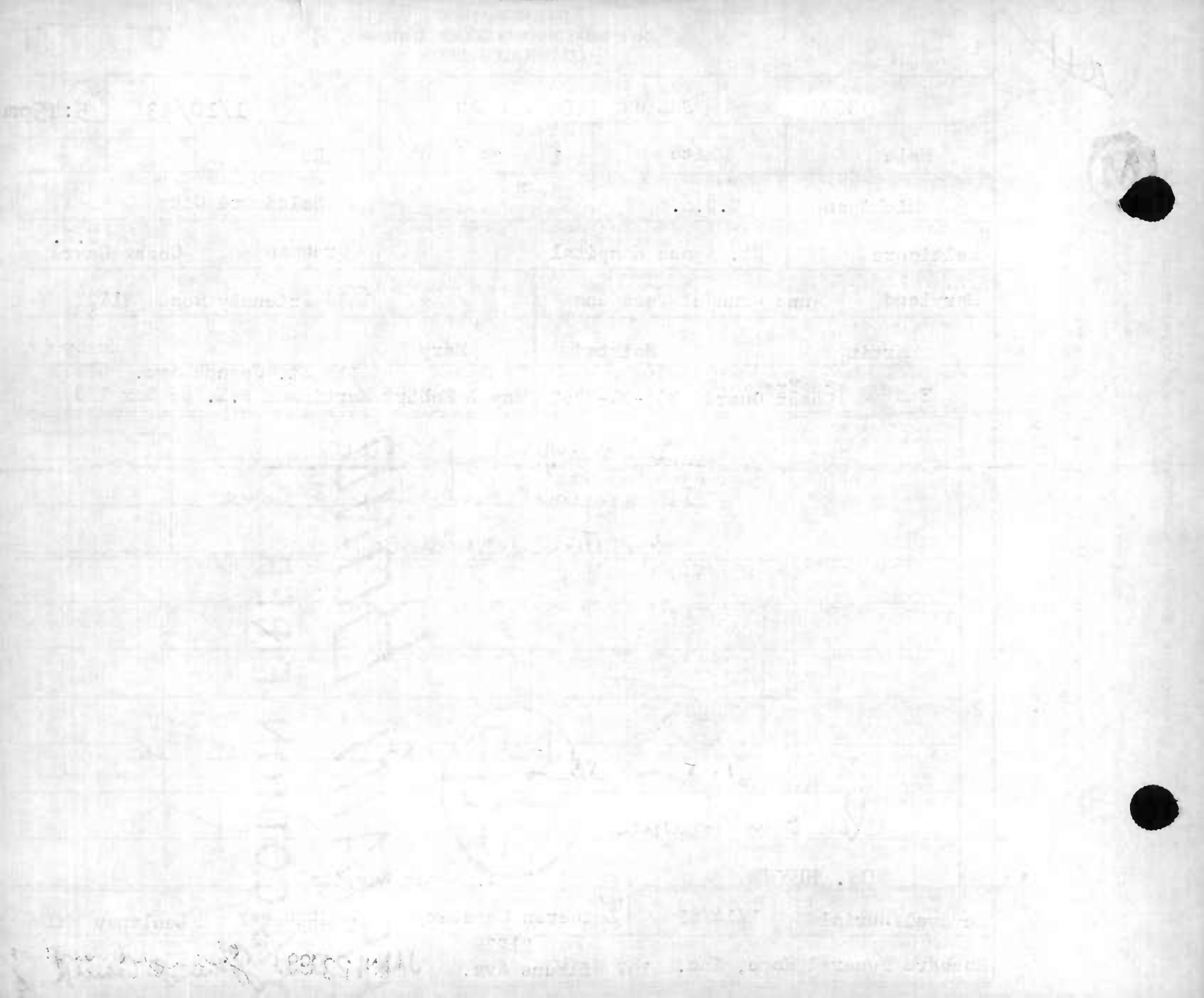
DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 9 7 8

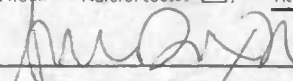
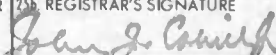
REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | 2a. DATE OF DEATH   |  | 2b. HOUR   |  |
|   |  | OSCAR JULIUS HALSTAD  |  | 1/10/83   |  | 5:45pm   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 29 02   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Michigan   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Crewman   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Coast Guard  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Anne Arundel   |  | 13c. CITY OR TOWN<br>Pasadena   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Martin  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Husby   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) YES 30 Yrs Coast Guard  |  |  |  |
|   |  | 16b. SOCIAL SECURITY NO.<br>366-34-2292   |  | 17. INFORMANT<br>115 St. Joseph Ave. 49682<br>Ray & Robert Martinson F.H. po Box 159  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u><br>5070<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Intracerebral hemorrhage &amp; Coma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Aspiration pneumonia.</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ( )  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-5</u> , 19 <u>83</u> , to <u>1-10</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>1-5</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Qui Dien Huynh</u>   |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. HUYNH  |  | 22e. ADDRESS<br>St. Agnes Hospital  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Removal/Burial   |  | 23b. DATE<br>1/14/83  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lutheran Cemetery   |  | 23d. LOCATION<br>Sutton Bay Township Leelanau MI   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc.  |  |   |  | 24b. ADDRESS<br>21229<br>4107 Wilkens Ave.  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 12 1983   |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Canfield</u>   |  |  |  |

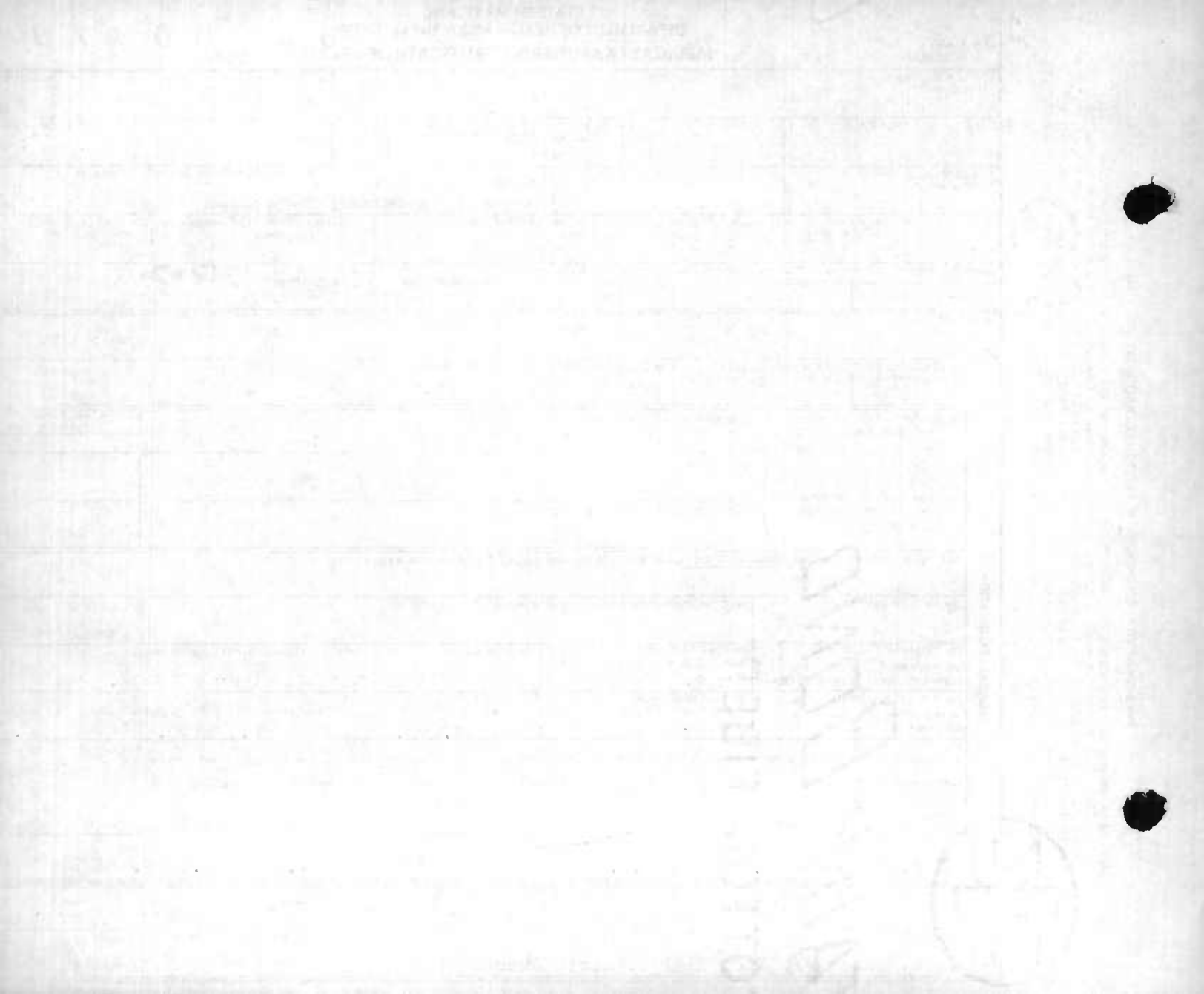


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAW 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |   |  | REG. NO. 00979  |  |
|--|--|--|--|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CLAUDE Lee Hamile (HAMIEL)</b>  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1 1 19 83</b>            |  | 2b. HOUR <b>11:10 AM</b>  |  |
| 3. SEX <b>male</b>   |  | 4. RACE <b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>4 30 30</b>                            |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>52 YRS</b>   |  | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN   |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>1 1 19 83</b>                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N. Carolina</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>   |  |   |  |
| 11. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>21202 1254 E. North Avenue</b>  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>N/A</b>   |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Essie Mae Hamile</b>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Unk.</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>243-50-5397</b>                               |  | 17. INFORMANT ADDRESS<br><b>Cofield F/H P.O. Box 72</b>  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>8147</b> IMMEDIATE CAUSE (a) <b>Cervical spine injury with complications</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |  |  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  | 21b. TIME OF INJURY<br>HOUR MONTH DAY YEAR<br><b>12:08 11-27-1982</b>        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Pedestrian struck by pick-up truck.</b>                      |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>street</b> |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Light St. no. of Pratt St., Balto. City Md.</b>  |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |  |  |  |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE    |  |  |  |  |  | TITLE (SPECIFY)<br>M.D. <b>Assistant</b>   |  | MEDICAL EXAMINER  |  | DATE SIGNED <b>1-4-83</b>   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>  |  |  |  |  |  | ADDRESS <b>111 Penn St., Balto., Md. 21201</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |  |  | 23b. DATE<br><b>1/8/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Piney Grove Cem.</b>  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Halifax Co. N.C.</b>               |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H Inc. 1101 E. north Avenue</b>  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 6 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br> |  |   |  |

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 9 8 0

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |   |   |   |
|--|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>NOVA C. HAMILTON  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JANUARY 17, 1983                   |   | 2b. HOUR<br>3:02 AM   |
| 3. SEX<br>Male   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov 16, 1905  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.                                | IF UNDER 1 YEAR<br>MONTHS DAYS                | IF UNDER 24 HRS.<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ohio  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                |   |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Hospital, Inc. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clerk | 12b. KIND OF BUSINESS OR INDUSTRY<br>Railroad |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland |  |   | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Rodgers Forge            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Jessie Hamilton  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Bertha Shoher            |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>705 05 7434   | 17. INFORMANT<br>ADDRESS<br>21212 Gertrude Hamilton 228 Rodgers Forge     |   |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST

1629

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) CANCER LUNG WITH METATISIS, C.R.F.

DUE TO, OR AS A CONSEQUENCE OF

(c) CONGESTIVE HEART FAILURE, G.I. BLEEDING, SEPSIS

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

|   |  |  |   |
|---|--|--|---|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (1) (this hospital) attended the deceased from JAN. 16, 1983, to JAN. 17, 1983 that (1) (we) last saw the deceased alive on JAN. 17, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br>MUKEL LUHAR   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br>Jan 17, 1983   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MUKEL LUHAR, M.D.  |  | 22e. ADDRESS<br>100 N. BROADWAY, BALTIMORE, MD. 21231                                |   |

|  |                         |  |  |
|--|-------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial     | 23b. DATE<br>Jan 20, 83 | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md. |
| 24. FUNERAL DIRECTOR<br>NAME<br>Dippel Funeral Homes, Inc. |                         | ADDRESS<br>7110 Belair Road<br>Baltimore, Md.          | 25a. DATE REC'D. BY REGISTRAR<br>JAN 19 1983                 |
|  |                         |  | 25b. REGISTRAR'S SIGNATURE<br>J. G. Carver                   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 3 0 0 9 8 1   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FRANCIS A. HAMMETT  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 9 83   |  |  |  |
| 3. SEX<br>MALE   |  |   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 06 16   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY, MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VETERANS ADMINISTRATION MEDICAL CENTER |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Deliveryman  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Essex 21221  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edmund Hammett   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ella Davis   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW1  |  | 17. INFORMANT<br>Rose Hammett, Wife   |  | 17. ADDRESS<br>Same  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u><br>+100<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that <u>X</u> (this hospital) attended the deceased from <u>JANUARY 3</u> , 19 <u>83</u> , to <u>JANUARY 9</u> , 19 <u>83</u> , that <u>X</u> (we) lost <u>above</u> the deceased alive on <u>JANUARY 9</u> , 19 <u>83</u> , and that in <u>X</u> (our) opinion death occurred on the date and hour and from the causes stated.                             |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Darla S. Holland, M.D.</u>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><u>1/9/83</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>DARLA S. HOLLAND, M.D.</u>   |  |   |  | 22e. ADDRESS<br><u>3900 LOCH RAVEN BLVD BALTO, MD 21218</u>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><u>Burial</u>   |  | 23b. DATE<br><u>1/12/83</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Holly Hill Memorial Gardens</u>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Baltimore Co., Md.</u>  |  |
| 24. FUNERAL DIRECTOR<br><u>Bruzdinski Funeral Home PA 1407 Old Eastern Ave</u>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>JAN 12 1983</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Smith</u>   |  |

BP

RECEIVED

THE UNITED STATES OF AMERICA

DEPARTMENT OF JUSTICE

WASHINGTON, D. C.

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C.

TO THE HONORABLE THE SENATE

WASHINGTON, D. C.

1/11/53

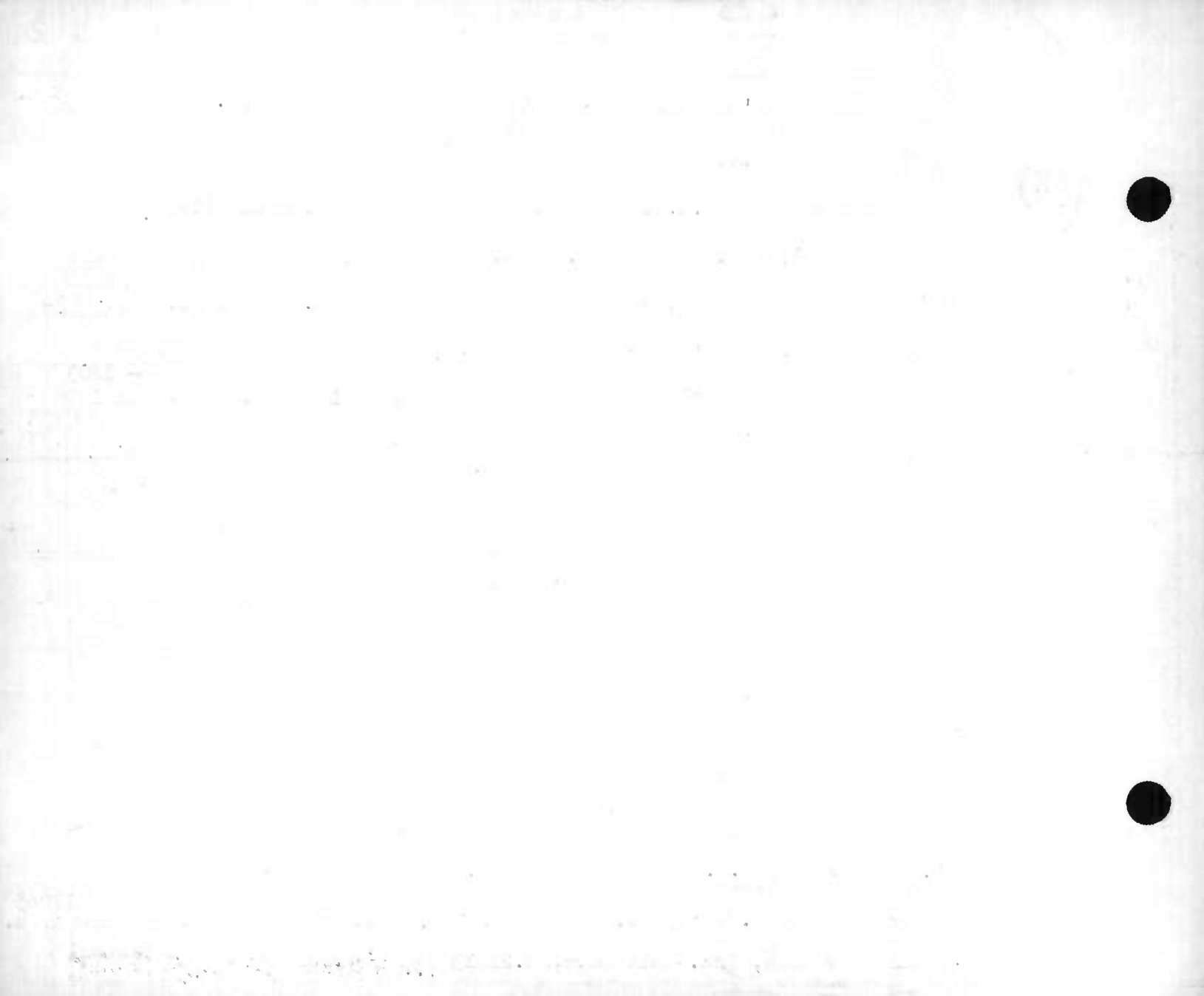
RECEIVED

U.S. DEPARTMENT OF JUSTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |   |  | 8 3 0 0 9 8 2                 |  |
|---|--|--|--|--|--|---|--|---|--|-------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.   |  |  |  |   |  |   |  |                               |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>LENA  |  | MIDDLE<br>O'DONNELL  |  | LAST<br>HAMMETT   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>January 3, 1983   |  | 2b HOUR<br>3:50 A.<br>M.      |  |
| 3 SEX<br>Female   |  | 4 RACE<br>White  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>May 15, 1890  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>92 YRS.   |  | 7a UNDER 1 YEAR<br>MONTHS DAYS  |  | 7b UNDER 24 HRS<br>HOURS MIN. |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>5 Pennsylvania  |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                    |  |   |  |                               |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3700 N. Charles St.- Apt.#703 |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                  |  | 12b KIND OF BUSINESS OR INDUSTRY<br>at Home   |  |                               |  |
| 13a STATE<br>Maryland   |  | 13b COUNTY<br>---  |  | 13c CITY OR TOWN<br>Baltimore  |  | 14 INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 15 STREET ADDRESS<br>21218<br>3700 N. Charles St.-Apt.#703-   |  |                               |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>George A. O'Donnell  |  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary J. McBride  |  |   |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) No  |  |                               |  |
| 16b SOCIAL SECURITY NO.<br>212-22-8888  |  |  |  | 17 INFORMANT<br>David G. Mock, V.P. 1st. Nat. Bank - Box 1596  |  |   |  | ADDRESS<br>-21203   |  |                               |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4140</u> <u>ventricular fibrillation</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>AS 4140</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>minutes</u><br><u>Years</u> |  |  |  |  |  |   |  |   |  |                               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Chronic Lymphatic Leukemia</u>   |  |  |  |  |  |   |  |   |  |                               |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                      |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                               |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |                               |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |                               |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>4/18</u> , 19 <u>75</u> , to <u>1/3</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>4/31</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) <u>view the body after death.</u>   |  |  |  |  |  |   |  |   |  |                               |  |
| 22b SIGNATURE<br><u>Mark Dugan</u>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  |   |  | 22c DATE SIGNED<br><u>1/4/83</u>  |  |                               |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>F. Mark Dugan, M.D.   |  |  |  | 22e ADDRESS<br>15 E. Biddle Street - 21202   |  |   |  |   |  |                               |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b DATE<br>Jan. 5, 1983   |  | 23c NAME OF CEMETERY OR CREMATORY<br>Mt. Holly Sprs. Cem.  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Mt. Holly Springs, Cumberland, Pa.               |  | 23e DATE REC'D. BY REGISTRAR<br>JAN 19 1983   |  |                               |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Henry Sander & Sons, Inc.  |  |  |  |  |  | ADDRESS<br>Baltimore, Md. 21213   |  | 25a DATE REC'D. BY REGISTRAR<br>JAN 19 1983   |  |                               |  |



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury or other traumatic event, the medical examiner must be notified at once.

FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 9 8 3

REG. NO.

|  |  |   |  |   |  |  |   |
|--|--|---|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MILDRED BESSIE LINK HAMPTON   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>01 30 83                           |   |  | 2b. HOUR<br>A M  |   |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 06 04  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS.                                 |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                 |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>407 S. BENTALOU STREET |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>PACKER |   |
|  |  |   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>STORAGE AND                           |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |   |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY<br>---  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13e. STREET ADDRESS<br>405 S. FURROW STREET, 21223                         |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>HERMAN LINK  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>AUGUSTA KUHLMAN  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO   |  |   |  | 16b. SOCIAL SECURITY NO.<br>213-20-2726   |  | 17. INFORMANT<br>ADDRESS<br>ETHEL MAY ENSEY 407 S. BENTALOU STREET 21223   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>1541 IMMEDIATE CAUSE (a) <i>Pregnancy lachemia and invasion</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Extensive carcinoma of rectum</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                      |  |   |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |  |   |  |  |   |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |   |  |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/26, 19 81, to 1/30, 19 83, that (I) (we) lost<br>saw the deceased alive on 1/25, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |   |
| 22b. SIGNATURE<br>M. A. Sarshar, M.D.  |  |   |  |   | DEGREE   |  | 22c. DATE SIGNED<br>1/31/81                     |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MIR-AHMAD SARSHAR, M.D.   |  |   |  |   | 22e. ADDRESS<br>PINE HEIGHTS & WILKENS AVENUES, 21229                          |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>02-02-83   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MEADOWRIDGE MEM. PK.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>ELKRIDGE HOWARD MARYLAND     |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.   |  |   |  | 25a. REG'D. BY REGISTRAR<br>FEB 2 1983  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Connel                               |   |

BP





2008 FEB 2 083

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 8 3 0 0 9 8 4  |  |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST<br>Carrie R. Lee Hand  |  |   |  | 2a. DATE OF DEATH   |  | MONTH DAY YEAR<br>1-10-83  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 28, 1894   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>88   |  | 7b. HOUR<br>6:52 AM  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Bon Secour Hospital                                 |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>--  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>2231 Riggs Avenue 21216   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Eldridge Ridgely   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mamie Unknown  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-22-8671   |  | 17. INFORMANT<br>Clifton Lee Hand   |  |   |  | ADDRESS<br>Same as # 13  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Coronary</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>OSCD</u>  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)<br><u>Diabetes Mellitus</u>  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/9</u> 19 <u>83</u> , to <u>1/10</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>1/9</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>ngayoso</u>   |  | DEGREE<br><u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Elmo Gayoso M.D.  |  | 22e. ADDRESS<br>Bon Secour Hospital 21223<br>2000 W. Baltimore Street, Baltimore, Md.  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>1/13/83   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lorraine Park Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.                                     |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <u>Leroy M. &amp; Russell C. Wittke Funeral Homes</u><br>ADDRESS <u>1630 Edmondson Avenue, C. tonsville, Md. 21228</u>  |  |  |  |   |  | 25. DATE REC'D. BY REGISTRAR<br>JAN 12 1983   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 3 0 0 9 8 5   |   |   |   |
|--|--|---|--|---|---|---|---|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO. 117/83   |   |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JAMES ARTHUR HARDEN</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>17</b> YEAR <b>83</b>                               |   | 2b. HOUR<br><b>9:41 AM</b>  |   |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>W</b>  | 5. DATE OF BIRTH<br>MONTH <b>02</b> DAY <b>24</b> YEAR <b>45</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>37</b> YRS.                                |   | IF UNDER 1 YEAR<br>MONTHS <b>00</b> DAYS <b>00</b>  |   | IF UNDER 24 HRS<br>HOURS <b>00</b> MIN. <b>00</b> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE, MD.</b>                    |   |   |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNIVERSITY HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF LAST YEAR) <b>HOUSEWORKER</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>COLLEGE</b> |   |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |   |   |
| 13a. STATE<br><b>MD</b>  | 13b. COUNTY<br><b>ALLEGANY</b>   | 13c. CITY OR TOWN<br><b>FROSTBURG</b>   | 13e. STREET ADDRESS<br><b>213, BOX 29 21532</b>                                  |   |   |   |   |
| 14. FATHER'S NAME<br>FIRST <b>JOHN</b> MIDDLE <b>HARDEN</b> LAST <b>HARDEN</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>ALICE</b> MIDDLE <b>STEELE</b> LAST <b>STEELE</b>  |  | ADDRESS <b>FROSTBURG, MD.</b>   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>UNK</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>220-52-7571</b>  |  | 17. INFORMANT<br><b>MRS. JAMES HARDEN, RT. 1, BOX 29,</b>                                       |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>3482</b> IMMEDIATE CAUSE (a) <b>CESSATION OF CEREBRAL FUNCTION</b>   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |   |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |   |  | (b) <b>CHRONIC MENINGITIS</b>   |   |   |   |
|  |  |   |  | (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>   |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>0</b>  |  |   |  |   |   |   |   |
| 19a. DATE OF OPERATION<br><b>11/3/83</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>INCREASED INTRACRANIAL PRESSURE</b>  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/7</b> 19 <b>83</b> , to <b>11/7</b> 19 <b>83</b> , that (I) (we) lost<br>saw the deceased alive on <b>11/7</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |   |   |
| 22b. SIGNATURE<br><b>ERIC CARSON MD</b> DEGREE <b>MD</b>   |  |   |  | 22c. DATE SIGNED<br><b>11/7/83</b>  |   | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ERIC CARSON MD</b>  |   |
| 22e. ADDRESS<br><b>UNIV OF MD HOSPITAL</b>   |  |   |  | 22f. ADDRESS<br><b>UNIV OF MD HOSPITAL</b>  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>   |  | 23b. DATE<br><b>1/10/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ECKHART CEM.</b>                                       |   | 23d. LOCATION<br>CITY OR TOWN <b>ECKHART</b> COUNTY <b>ALLEGANY</b> STATE <b>MD.</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>SOWERS FUNERAL HOME</b> ADDRESS <b>60 W. MAIN ST. FROSTBURG</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 17 1983</b>   |   |   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>  |  |   |  |   |   |   |   |

BP \_\_\_\_\_

TO ALLIED STATES OF AMERICA  
10 15 1945

(M)

JAMES HARRIS

RECEIVED

10 15 1945

XXXX

ALLIANCE

STREET

ALICE

BARBARA

JOHN

PROCESSED BY

MR. JAMES HARRIS, 1015, 1015

10/15

ALLIANCE

10/15

RECEIVED

10 15 1945

TO ALLIED STATES OF AMERICA

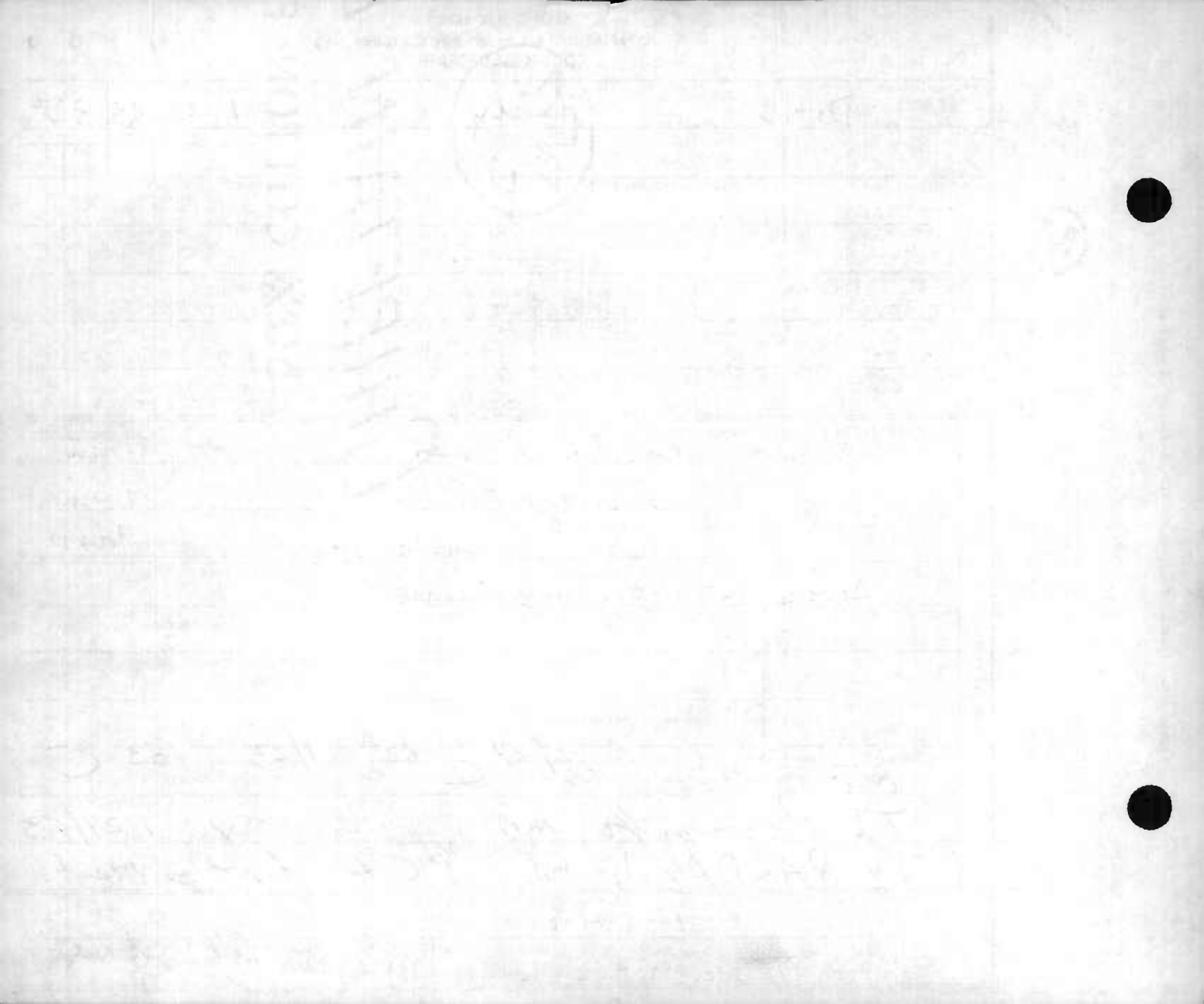
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial permit. Then please remove containing papers. Page 1 and 2 should be returned to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |                              |  |  |  |  |   |  |                                   |  | 8300986 |
|--|------------------------------|--|--|--|--|---|--|-----------------------------------|--|---------|
| 1. FOR STATE REGISTRAR   |                              | 2a. DATE OF DEATH  |  |  |  | 2b. HOUR  |  |                                   |  |         |
| 1. DECEASED NAME (TYPE OR PRINT)   |                              | 2a. DATE OF DEATH  |  |  |  | 2b. HOUR  |  |                                   |  |         |
| Doris Hardy  |                              | 1 23 83  |  |  |  | 8:34 PM   |  |                                   |  |         |
| 3. SEX   | 4. RACE                      | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. IF UNDER 1 YEAR  |  | 7. IF UNDER 24 HRS                |  |         |
| Female   | Black                        | 11 24 29   |  | 53 YRS.  |  | MONTHS DAYS   |  | HOURS MIN.                        |  |         |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 8b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |                                   |  |         |
| Maryland   | U.S.A.                       |  |  | Baltimore City, MD.  |  |   |  |                                   |  |         |
| 10. CITY OR TOWN OF DEATH  |                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |         |
| Baltimore  |                              | Baltimore City Hospital  |  |  |  |   |  |                                   |  |         |
| 13a. STATE   |                              | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS               |  |         |
| Maryland   |                              |  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 913 Shutter St. 21205             |  |         |
| 14. FATHER'S NAME  |                              | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |                                   |  |         |
| Charles Mills  |                              | Martha Cheeks  |  |  |  |   |  |                                   |  |         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |                              | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |   |  |                                   |  |         |
| No   |                              | N/A  |  | Martha Mills 913 Shutter Street  |  |   |  |                                   |  |         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |                              |  |  |  |  |   |  |                                   |  |         |
| PART 1. DEATH WAS CAUSED BY:   |                              |  |  |  |  |   |  |                                   |  |         |
| IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>  |                              |  |  |  |  |   |  |                                   |  |         |
| 3481   |                              |  |  |  |  |   |  |                                   |  |         |
| DUE TO, OR AS A CONSEQUENCE OF   |                              |  |  |  |  |   |  |                                   |  |         |
| (b) <u>Respiratory Failure</u>   |                              |  |  |  |  |   |  |                                   |  |         |
| DUE TO, OR AS A CONSEQUENCE OF   |                              |  |  |  |  |   |  |                                   |  |         |
| (c) <u>Anoxic Brain Damage</u>   |                              |  |  |  |  |   |  |                                   |  |         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |                              |  |  |  |  |   |  |                                   |  |         |
| <u>Severe restrictive lung disease</u>   |                              |  |  |  |  |   |  |                                   |  |         |
| 19a. DATE OF OPERATION   |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                                   |  |         |
|  |                              |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                                   |  |         |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |                              | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |                                   |  |         |
|  |                              | P.M. 19  |  |  |  |   |  |                                   |  |         |
| 21d. INJURY OCCURRED   |                              | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION  |  |   |  |                                   |  |         |
| WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                              |  |  | CITY OR TOWN COUNTY STATE  |  |   |  |                                   |  |         |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>12/27</u> , 19 <u>82</u> , to <u>1/23</u> , 19 <u>83</u> , that (1) (we) lost saw the deceased alive on <u>1/23</u> , 19 <u>83</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) not view the body after death. |                              |  |  |  |  |   |  |                                   |  |         |
| 22b. SIGNATURE   |                              | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED  |  |                                   |  |         |
| TV PARRAN Jr MD  |                              |  |  |  |  | 1/24/83   |  |                                   |  |         |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |                              | 22e. ADDRESS   |  |  |  |   |  |                                   |  |         |
| TV PARRAN Jr MD  |                              | BCH Dept of Med.   |  |  |  |   |  |                                   |  |         |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |                                   |  |         |
| BURIAL   |                              | 1/27/83  |  | Mount Calvary Cem  |  | Baltimore Co. Md.   |  |                                   |  |         |
| 24. FUNERAL DIRECTOR   |                              | 25a. DATE RECEIVED BY REGISTRAR  |  | 25b. REGISTRAR SIGNATURE   |  |   |  |                                   |  |         |
| Wm. C. March F/H Inc.  |                              | JAN 25 1983  |  | John J. Smith  |  |   |  |                                   |  |         |
| NAME   |                              | ADDRESS  |  |  |  |   |  |                                   |  |         |
|  |                              |  |  |  |  |   |  |                                   |  |         |

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Items #3&amp;6 Film G576 2/24/83 rc

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 00987

FOR  
1- STATE  
REGISTRAR

REG. NO.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>HENRY H. HARNEK  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JANUARY 8 1983                       |  | 2b. HOUR<br>8:05 PM  |
| 3. SEX<br>MALE  | 4. RACE<br>CAUC   | 5. DATE OF BIRTH<br>June 12, 1918<br>47 5/16 YRS.   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 64 YRS.                               |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO, MD.                          |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>N. CHARLES GEN |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br>MD.   |   |   | 13b. COUNTY   | 13c. CITY OR TOWN<br>BALTO.  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST ? LAST   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST ? MIDDLE ? LAST                           |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-09-7099  | 17. INFORMANT<br>WIFE   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u><br>4275<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ASPIRATION</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>CA OF PANCREAS   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>DEC-28</u> 19 <u>82</u> to <u>JAN-8</u> 19 <u>83</u> , that (I) (we) lost<br>saw the deceased alive on <u>JAN-8</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.          |   |   |   |  |  |
| 22b. SIGNATURE<br><u>C. Vergara - Soares</u>  |   | DEGREE<br>M.D.  |   | 22c. DATE SIGNED<br>1-8-83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>C. VERGARA - SOARES  |   | 22e. ADDRESS<br>N. CHARLES GEN. HOSP. BALTO. MD. 21218  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |   | 23b. DATE<br>1/13/83  | 23c. NAME OF CEMETERY OR CREMATORY<br>LAKE VIEW MEN                         |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>CARROLL CO., MD.   |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Paul E. Chawins</u>  |   | ADDRESS<br>3617 Portland Ave  |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 13 1983                                   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

33 00988

|   |  |   |   |  |                                   |
|---|--|---|---|--|-----------------------------------|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 2a. DATE OF DEATH   |   | 2b. HOUR   |                                   |
| DECEASED NAME<br>(TYPE OR PRINT)  |  | MONTH DAY YEAR  |   | HOURS MIN.   |                                   |
| LEROY   |  | 1-23-83   |   | 8:45 AM  |                                   |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)                               | IF UNDER 1 YEAR  |                                   |
| MALE  | COL  | MONTH DAY YEAR  | 69  | IF UNDER 24 HRS  |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |                                   |
| VA  | U.S.A  |   | BALTIMORE CITY MD.  |  |                                   |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| BALTIMORE   | 1908 CEBRIC ROAD   |   | RETIRED   |  |                                   |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. STREET ADDRESS   |  |                                   |
| MARYLAND  |  | BALTIMORE   | 1908 CEBRIC ROAD 21216  |  |                                   |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |   |  |                                   |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST   |   |  |                                   |
| WILLIAM HARRELL   |  | ANNIE ABBEY   |   |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS  |                                   |
| NO  |  | 220 09 4577   |   | MRS GAIL HARRELL CAMPBELL 1908 CEBRIC ROAD                                     |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Adenocarcinoma, Unknown Primary</u><br>1991<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Approximate interval between onset and death: <u>8 months</u>                   |  |   |   |  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>None</u>   |  |   |   |  |                                   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?  |                                   |
| 12/1/83   |  | Bilateral Ureteral Obstruction  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                   |
|   |  | P.M. 19   |   |  |                                   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE                                     |                                   |
|   |  |   |   |  |                                   |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>July 1/21</u> 19 <u>82</u> to <u>1/23</u> 19 <u>83</u> , that (1) (we) last saw the deceased on <u>1/21</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |   |   |  |                                   |
| 22b. SIGNATURE  |  | DEGREE  |   | 22c. DATE SIGNED   |                                   |
| Earl Steinberg, MD  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>    |   | 1/25/83  |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |   |  |                                   |
| EARL STEINBERG  |  | Carnegie 330 Johns Hopkins Hospital   |   |  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY   |                                   |
| BURIAL  |  | 1-29-83   |   | MD. NAT. MEM. CEM.   |                                   |
| 24. FUNERAL DIRECTOR  |  | 24b. ADDRESS  |   | 25a. DATE REC'D. BY REGISTRAR  |                                   |
| NAME  |  | 25b. REGISTRAR'S SIGNATURE  |   | 25c. DATE REC'D. BY REGISTRAR  |                                   |
| JOSEPH L. RUSS  |  | 2222 W. NORTH AVE   |   | JAN 31 1983  |                                   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove correlative pages. Pages 1 and 2 should be filed within 27 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8300989

REG. NO.

|   |                       |   |  |   |  |
|---|-----------------------|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ELIZABETH ROLLAND HARRIS</b>  |                       | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01 01 83</b>  |  | 2b. HOUR<br><b>4 P</b>  |  |
| 3. SEX<br><b>F</b>  | 4. RACE<br><b>CAU</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 06 1905</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>SCOTLAND</b>  |                       | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b>   |                       | 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b>                      |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>INSPECTOR</b>  |                       | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>PAPER BAG CO.</b>   |  | 13a. STATE<br><b>MARYLAND</b>   |  |
| 13b. COUNTY<br><b>---</b>   |                       | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN ROLLAND</b>   |                       | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>JANE McLAUGHLIN</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]<br><b>NO</b>   |  |
| 16b. SOCIAL SECURITY NO.<br><b>213-18-1562</b>  |                       | 17. INFORMANT<br><b>FRED C. HARRIS</b>  |  | ADDRESS<br><b>478 KENILWORTH COURT</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>HEPATIC FAILURE</b><br><b>1539</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>METASTATIC CA COLON</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |                       |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>---</b>   |                       |   |  |   |  |
| 19a. DATE OF OPERATION  |                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                       | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                       | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                       | 22a. I certify that (I) (this hospital) attended the deceased from <b>12-15-1983</b> , to <b>1-1-1983</b> , that (I) (we) last saw the deceased alive on <b>1-1-1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |
| 22b. SIGNATURE<br><b>NAEEM A. Siddiqi</b>   |                       | DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  | 22c. DATE SIGNED<br><b>1-1-83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>NAEEM A. Siddiqi</b>  |                       | 22e. ADDRESS<br><b>ST. AGNES HOSP.</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |                       | 23b. DATE<br><b>01-04-83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MEADOWRIDGE MEM. PARK</b>  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ELKRIDGE HOWARD MARYLAND</b>   |                       | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229</b>   |  |   |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 3 1983</b>  |                       | 25b. REGISTRAR'S SIGNATURE<br><b>John J. [Signature]</b>  |  |   |  |

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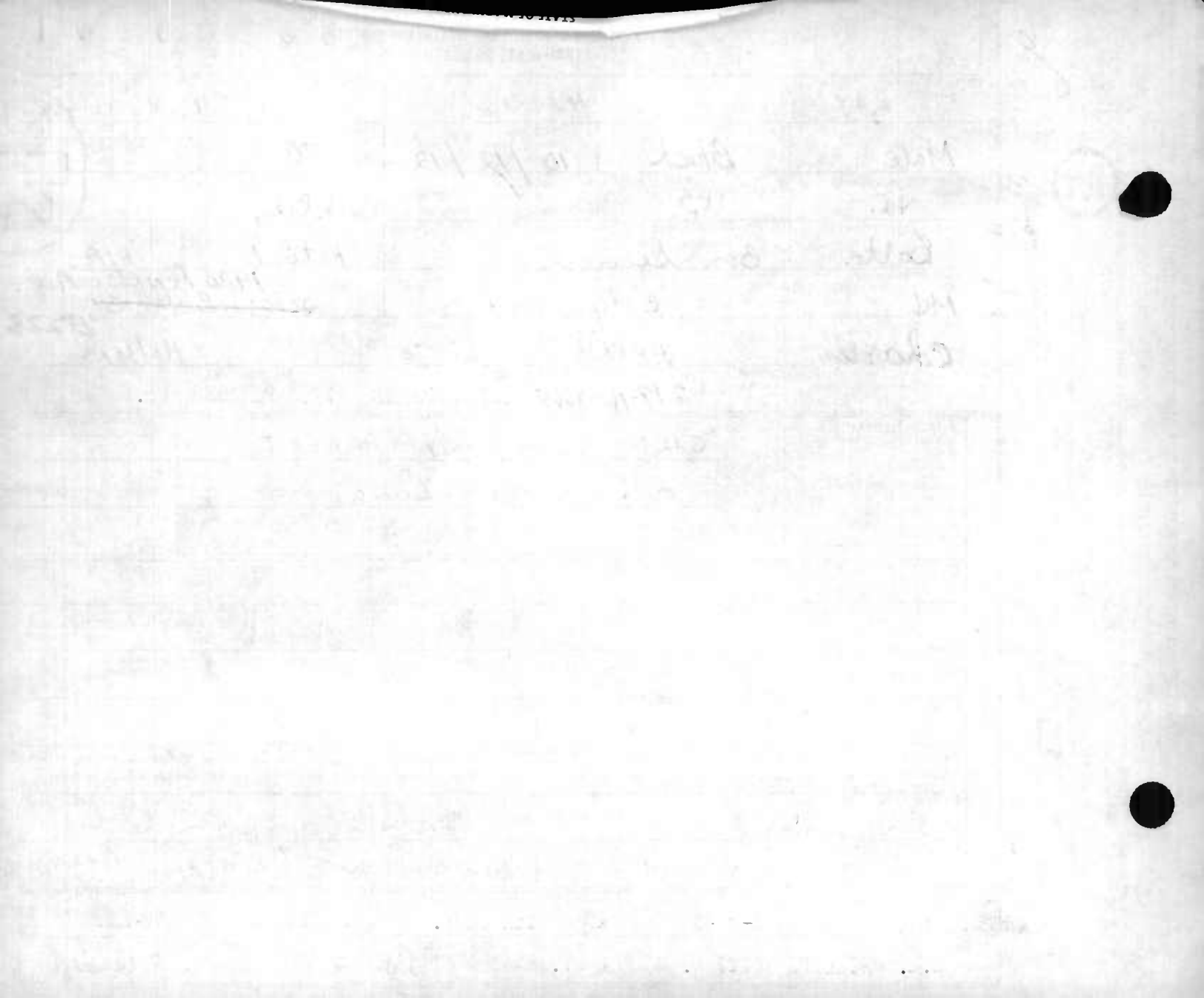
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |   |   |  |   |  | REG. NO.  |  |
|--|--|--|--|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>RAY</b>   |  |  |  |  | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>1</b> YEAR <b>83</b> |   |  |   |  | 2b. HOUR<br><b>6.45 P</b>                       |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>10</b> DAY <b>12</b> YEAR <b>12</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  |  | IF UNDER 24 HRS<br>HOURS <b></b> MIN. <b></b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Va.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.                                  |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secour</b> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>N/A</b>   |  |   |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b></b>   |  | 13c. CITY OR TOWN<br><b>CITY</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1920 Penrose Ave.<br/>2800 W. Balto. St</b>   |  |   |  |
| 14. FATHER'S NAME<br><b>Charles</b> MIDDLE <b></b> LAST <b>HARRIS</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br><b>Willie</b> FIRST <b></b> MIDDLE <b></b> LAST <b>Holland</b>   |   |   |  | 21223   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br><b>217-16-8665</b>   |  | 17. INFORMANT<br><b>BETHA HARRIS</b>   |   |   |  | ADDRESS<br><b>1920 PENROSE AVE.</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>1629</b> IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CARCINOMA LUNG.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>  |  |  |  |  |   |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |  |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>NA</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>NA</b>  |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>NA</b> <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)<br><b>NA</b>  |   |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>NA</b>  |  | 21f. LOCATION<br>STREET <b>NA</b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>  |   |   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-29-</b> 19 <b>82</b> , to <b>1-1-</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1-1-</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Surjit A. Julka</b>   |  |  |  | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   |  | 22c. DATE SIGNED<br><b>1-1-83</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SURJIT JULKA</b>   |  |  |  | 22e. ADDRESS<br><b>BON SECOUR HOSPITAL, BALTIMORE</b>  |   |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>1-5 83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL CEMT.</b>  |   | 23d. LOCATION<br>CITY OR TOWN <b>BALTIMORE</b> COUNTY <b></b> STATE <b>MARYLAND</b>             |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>E.L. PHILLIPS</b> ADDRESS <b>1721 N. MONROE ST.</b>  |  |  |  |  |   | 25a. DATE RECD. BY REGISTRAR<br><b>JAN 4 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canfield</b>   |  |   |  |

BP



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE  
REGISTRAR

|   |  |  |  |   |  |   |  |   |  |
|---|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Maurice Harrison   |  |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br>1 1 19 83   |  |   |  | 2b. HOUR<br>M<br>3:23<br>a. M   |  |
| 3. SEX<br>male  |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 22 57   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>25 YRS.   |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>1 1 19 83                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                     |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>front of 121 S. Calhoun Street |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>5697 Perdue Ave. Apt. 01                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Clinton Harrison  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Naomi Carter   |  |   |  | 121239  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO   |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-70-4922  |  | 17. INFORMANT ADDRESS<br>Denise Thompson 3150 Ravenwood Ave.                                    |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple Stab Wounds<br>9660<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>(c)   |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>3:10 PM 1 1 19 83   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject was stabbed  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>on street   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>front of 121 S. Calhoun St., Balto., Md.   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .<br>Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br>Dennis F. Smyth, M.D.   |  | TITLE (SPECIFY)<br>Assistant   |  |   |  | MEDICAL EXAMINER  |  | DATE SIGNED<br>1-1-83   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Dennis F. Smyth, M.D.   |  | ADDRESS<br>111 Penn Street   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>1/6/83  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.                                     |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H Inc.   |  |  |  | ADDRESS<br>1101 E. North Avenue   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 4 1983   |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Conner  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE HEALTH DEPARTMENT. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

REPORT TO THE BOARD OF DIRECTORS  
ON THE PROGRESS OF THE WORK  
DURING THE YEAR 1900

1900

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1900

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   | 8 3 0 0 9 9 3   |  |   |  |                                   |  |  |
|---|--|--|--|---|---|--|---|--|-----------------------------------|--|--|
| 1. STATE REGISTRAR  |  |  |  |   | REG. NO.  |  |   |  |                                   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Ralph Harrison</b>   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 30 83</b>   |  |   |  |                                   | 2b. HOUR<br><b>M</b>   |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12. 13 18</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.                              |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>64</b>  |                                   | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>64</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>             |   |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>746 Bartlett St.</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |   |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>746 Barlett St. 21218</b> |  |                                   |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   |  |   |  |                                   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Truman Harrison</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rachelle Williams</b>   |   |  |   |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>220-07-9204</b>  |   | 17. INFORMANT ADDRESS<br><b>Mary Agnes Harrison 746 Barlett St.</b>            |   |  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1629</b> IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Squamous Cell Ca Lung.</b><br>(b) <b>Squamous Cell Ca Lung.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Brain Metastasis</b> |  |  |  |   |   |  |   |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |                                   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>October 1982</b> to <b>Jan 30 1983</b> , that (I) (we) last saw the deceased alive on <b>Jan 8 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |   |  |   |  |                                   |  |  |
| 22b. SIGNATURE<br><b>André F. L. F. MD</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   |  |   | 22c. DATE SIGNED<br><b>1/31/83</b>   |                                   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ANDRE F. L. F. MD</b>   |  |  |  | 22e. ADDRESS<br><b>Dept Fam. Med, Univ MD Hosp 21201</b>  |   |  |   |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>  |  |  |  | 23b. DATE<br><b>2/4/83</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cem.</b>                    |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                   |                                   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H Inc. 1101 E. North Avenue</b>   |  |  |  | 25. DATE RECEIVED BY REGISTRAR<br><b>FEB 1 1983</b>   |   |  |   |  |                                   |  |  |

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2022-00-01-11

CHEERMAN





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  | 8 3 0 0 9 9 4  |  |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.  |  |   |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Thurman Lee Harrison Jr.</i>  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>1 23 83</i>   |  | 2b. HOUR<br><i>1:30 A.M.</i>   |  |  |  |
| 3. SEX<br><i>male</i>  |  | 4. RACE<br><i>Caucasian</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>8 6 15</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>68</i> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>North Carolina</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>US</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                               |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Balto</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Good Samaritan Hosp</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. STATE<br><i>Maryland</i>  |  | 13b. COUNTY<br><i>St. Mary's</i>  |  | 13c. CITY OR TOWN<br><i>California</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>Box 149 Woodland Acres 20619</i>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Thurman Lee Harrison</i>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Frances Dupree</i>  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <i>Yes</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>231-01-467</i>   |  | 17. INFORMANT<br>ADDRESS<br><i>T.L. Harrison 111 same as 13e</i>  |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><i>4275 IMMEDIATE CAUSE (a) Cardio pulmonary arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.<br><i>Rheumatoid Arthritis</i>   |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/22</i> , 19 <i>83</i> , to <i>1/23</i> , 19 <i>83</i> that (I) (we) last saw the deceased alive on <i>1/23</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.     |  |   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Bram</i>  |  |   |  |   |  | DEGREE<br><i>MD</i>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>1/23/83</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Bram Buckerman</i>   |  |   |  |   |  | 22e. ADDRESS<br><i>Baltimore City Hospital</i>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  |   |  | 23b. DATE<br><i>Jan. 27, 1983</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Longwood Cemetery</i>                                  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Bedford Va.</i>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>W. Clarke Mattingley Leonardtown, Md.</i>   |  |   |  |   |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 26 1983</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Canfield</i>  |  |

BP

CDE 83-297A

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8300995

FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |  |                           |   |  |
|--|--|--|--|--|---------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>VIVIAN HARRISON</b> |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01-03-83</b> |  | 2b. HOUR<br><b>4:15pm</b> |   |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 25 1896</b>   |                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86 YRS.</b><br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S. Carolina</b>                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Home Hospital</b> |  |  |                           | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |                           | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>N/A</b>                               |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>N/A</b>  |  | 13e. STREET ADDRESS<br><b>1922 McCullough St, 21217</b>  |                           |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b> |  | 16b. SOCIAL SECURITY NO.<br><b>215-05-2612</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mildred Gales 1701 Eutaw Place</b>  |                           |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **LEUKEMIA AND RENAL FAILURE**

2089

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                           |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) this hospital attended the deceased from <b>12-14-</b> , 19 <b>82</b> , to <b>01-03-</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>01-03-</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>A. P. Nazemi M.D.</b>   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/3/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. A.F. NAZEMI M.D.</b>   |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION<br/>100 N. BROADWAY BALTIMORE, MARYLAND 21231</b> |  |  |  |   |  |

|   |  |                            |  |  |  |  |  |
|---|--|----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                             |  | 23b. DATE<br><b>1/6/83</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Veteran cem</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crownsville Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H Inc. 1101 E. north Avenue</b> |  |                            |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 6 1983</b>           |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>                  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 1 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For retention by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 0 9 9 6

|  |  |   |  |
|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 2a. DATE OF DEATH   |  |
| FIRST MIDDLE LAST<br>Mary Clara Harry  |  | MONTH DAY YEAR<br>January 10, 1983  |  |
| 2b. HOUR<br>4:34 P.M.  |  |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 4 98   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto., Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Housework  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |  |
| 13c. CITY OR TOWN<br>Dundalk   |  | 13d. INSIDE CITY LIMITS?<br>XXXX NO <input checked="" type="checkbox"/>   |  |
| 13e. STREET ADDRESS<br>1608 Searles Road 21222   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Ontt  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Braunsweiger  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-36-6586  |  |
| 17. INFORMANT<br>ADDRESS<br>Joseph E. Harry 1608 Searles Rd. 21222   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial infarction with rupture of inter-ventricular septum.</u><br>5570<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Acute Infarction of the segment of the small bowel.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (X) (this hospital) attended the deceased from January 9, 19 83, to January 10, 19 83, that X (we) last saw the deceased alive on above, (X) (we) (did) (do not) view the body after death.  |  |   |  |
| 22b. SIGNATURE<br>Keith Admas M.D.   |  | 22c. DATE SIGNED<br>1/11/83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Keith Admas, M.D.   |  | 22e. ADDRESS<br>c/o Maryland General Hospital   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>1-14-83  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore City, Md.   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>C.S. Zeiler & Son Inc. 901 S. Conkling Street  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 12 1983  |  |
| 25b. REGISTRAR'S SIGNATURE<br>John J. Connel   |  |   |  |

BP 24



Belknap County

1-11-33

revised. 10/8

X



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |                   |  |  |   |                                   |  |  |
|--|--|--|--|--|-------------------|--|--|---|-----------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |  |  | 2a. DATE OF DEATH |  |  |   |                                   | 2b. HOUR   |  |
| FRANCIS J. HARTLOVE  |  |  |  |  | JANUARY 12, 1983  |  |  |   |                                   | 10:45 P.M.   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |                   | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. UNDER 1 YEAR   |                                   | 8. UNDER 24 HRS  |  |
| Male   |  | White  |  | Nov. 22, 1937  |                   | 45 YRS.  |  | MONTHS  |                                   | DAYS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |                                   |  |  |
| Maryland   |  | U.S.A.   |  |  |                   | Baltimore City, MD.  |  |   |                                   |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| Baltimore  |  | Church Hospital Corporation  |  |  |                   | Bartender  |  |   | Restaurant                        |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  |                   |  |  |   |                                   |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |                   | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS   |                                   |  |  |
| Maryland   |  | 21231  |  | Baltimore  |                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 329 S. Durham St. 21231   |                                   |  |  |
| 14. FATHER'S NAME  |  |  |  |  |                   | 15. MOTHER'S MAIDEN NAME   |  |   |                                   |  |  |
| FRANCIS J. HARTLOVE  |  |  |  |  |                   | LEOVA FOWLER   |  |   |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  |  |                   | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS   |                                   |  |  |
| No   |  |  |  |  |                   | 216-36-3488  |  | Louise S. Castle 329 S. Durham St. 21231                            |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |                   |  |  |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| IMMEDIATE CAUSE (a) OAT CELL CARCINOMA OF THE LUNG   |  |  |  |  |                   |  |  |   |                                   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)   |  |  |  |  |                   |  |  |   |                                   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |                   |  |  |   |                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |                   |  |  |   |                                   |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                   |  |  | 20a. AUTOPSY?   |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  |  |                   |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY  |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |                                   |  |  |
|  |  |  |  | P.M. 19  |                   |  |  |   |                                   |  |  |
| 21d. INJURY OCCURRED   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                   | 21f. LOCATION  |  |   |                                   |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |  |  |                   | STREET CITY OR TOWN COUNTY STATE   |  |   |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from JANUARY 12, 19 83, to JANUARY 12, 19 83, that (I) (we) lost saw the deceased alive on JANUARY 12, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |                   |  |  |   |                                   |  |  |
| 22b. SIGNATURE   |  |  |  | DEGREE   |                   |  |  | 22c. DATE SIGNED  |                                   |  |  |
| AHMED NOUR   |  |  |  | MD   |                   |  |  | 1-13-83   |                                   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |                   |  |  |   |                                   |  |  |
| JOHN BARTHOLOMEW   |  |  |  | CHURCH HOSPITAL CORPORATION<br>100 NORTH BROADWAY BALTO. M.D. 21231  |                   |  |  |   |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                   |  |  | 23d. LOCATION   |                                   |  |  |
| Cremation  |  | Jan. 13, '83   |  | Green Mount Cemetery Baltimore, MD   |                   |  |  | CITY OR TOWN COUNTY STATE   |                                   |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |                   |  |  | 25b. REGISTRAR'S SIGNATURE  |                                   |  |  |
| William E. Johnson 8521 Loch Raven Blvd.   |  |  |  | JAN 13 1983  |                   |  |  | John J. Conner  |                                   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 300-3535.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 83 00998  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <sup>FIRST</sup> <u>Henry</u> <sup>MIDDLE</sup> <u>Christopher</u> <sup>LAST</sup> <u>Hartman</u>  |  |  |  | 2b. HOUR <u>11 05 A.M.</u>   |  |   |  |
| 3. SEX <u>Male</u>  |  | 4. RACE <u>Caucasian</u>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <u>1 30 1944</u>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <u>88</u> <del>80</del> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Balto., Md.</u>  |  | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD   |  |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Baltimore City Hospitals</u> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Retired</u>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <u>Fed. Yeast Co.</u>   |  |
| 13a. STATE <u>Maryland</u>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN <u>Baltimore</u>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  | 13e. STREET ADDRESS <u>4803 Fleet Street 21224</u>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>   |  | 16b. SOCIAL SECURITY NO. <u>579-03-725</u>   |  | 17. INFORMANT <u>Mary E. Hartman</u>   |  | ADDRESS <u>4803 Fleet Street 21224</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><u>4149</u> IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>hypertension</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>myocardial infarction</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 min</u>   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>chronic lymphocytic leukemia</u>  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/23</u> , 19 <u>83</u> , to <u>1/26</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on above <u>1/26</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |
| 27b. SIGNATURE <u>M. Ferguson</u>   |  |  |  | DEGREE <u>MD</u>   |  | 27c. DATE SIGNED <u>1/26/83</u>   |  |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>M. FERGUSON</u>  |  |  |  | 27e. ADDRESS <u>BALTO CITY HOSP</u>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>   |  | 23b. DATE <u>1-29-83</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cem.</u>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Dundalk, Balto. Co., Md.</u>   |  |
| 24. FUNERAL DIRECTOR NAME <u>C.S. Zeiler &amp; Son Inc.</u> ADDRESS <u>6224 Eastern Avenue</u>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <u>JAN 28 1983</u> REGISTRAR'S SIGNATURE <u>John J. Gassick</u>  |  |   |  |

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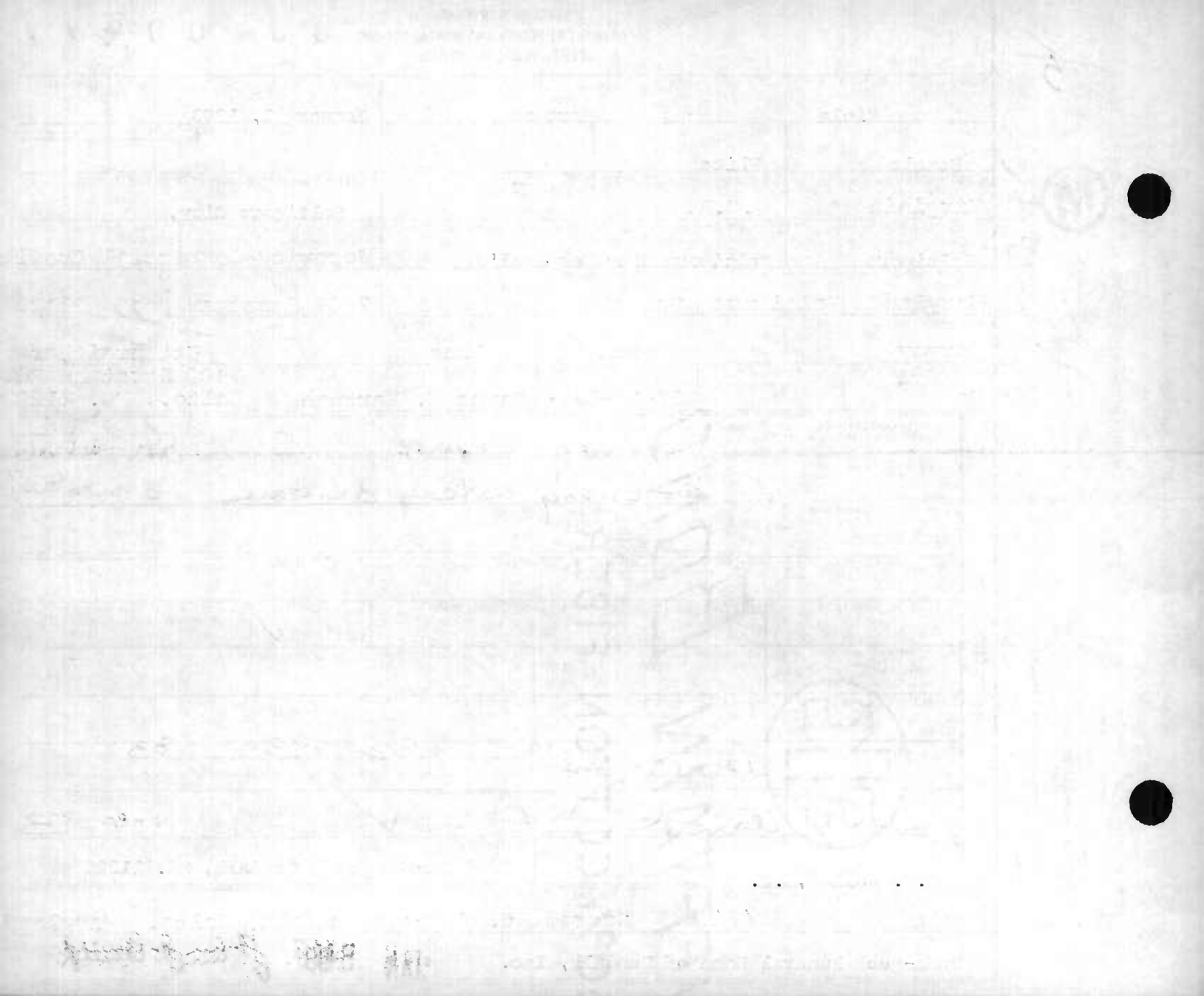


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 3 0 0 9 9 9   |  |  |  |
|---|--|---|--|---|--|--|--|
| FOR<br>STATE<br>REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Viola B. Hartman</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 3, 1983</b>   |  | 2b. HOUR<br>M<br><b>AM</b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 21 1920</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospital's</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Security-Commercial Credit</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Dundalk</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harvey Beach</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Uttenreither</b>   |  | 13e. STREET ADDRESS<br><b>7909 Stratman Road 21222</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>220-03-1004</b>   |  | 17. INFORMANT<br><b>James W. Hartman</b>  |  | ADDRESS <b>7909 Stratman Rd. Balto., MD. 21222</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4149</b> IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Coronary artery disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>3 months?</b>   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 months?</b>  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7-12-</b> 19 <b>82</b> to <b>1-3-</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>12-15-</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>B. W. Sallod, M.D.</b>   |  |   |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>1-4-83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>B. W. Sallod, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>2900 Dunran Road, Dundalk, Md. 21222</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/7/1983</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Ht. Of Jesus</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Dundalk Balto. Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 5 1983</b>  |  |  |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 3 0 1 0 0 0   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1- FOR STATE REGISTRAR   |  |  |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>WILLIAM H. HARTSOCK  |  |  |  | 2a. DATE OF DEATH<br>1/22/83  |  | 2b. HOUR<br>4:25 PM   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>July 1, 1909  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN)<br>Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  | 17a. USUAL OCCUPATION<br>Management (WORKING LIFE)  |  | 17b. KIND OF BUSINESS OR<br>Occupation (WORKING LIFE)<br>Hotel  |  |
| 12. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>Maryland Baltimore  |  |  |  | 13a. CITY OR TOWN<br>Towson   |  | 13b. STREET ADDRESS<br>22 BT Lambourne Road 21204   |  |
| 14. FATHER'S NAME<br>William Henry Hartsock  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>Ruth Mae Turner   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW 2 401-30-0563  |  | 17. INFORMANT ADDRESS<br>Mrs. Gladys Mae Hartsock same as 13e   |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>4280 IMMEDIATE CAUSE (a) Cardio-pulmonary Arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Congestive Heart Failure 4 years<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>none |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br>none   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-17, 19 83, to 1-22, 19 83, that (I) <input checked="" type="checkbox"/> saw the deceased alive on 1-22, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> We did (did not) view the body after death.  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br>DEBORAH THOMPSON MD  |  |  |  | 22c. DATE SIGNED<br>1/22/83   |  | 22d. ADDRESS<br>Union Memorial Hospital   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>1-25-1983   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY<br>Cockeysville Maryland   |  |
| 24. FUNERAL DIRECTOR<br>NAME Ruck Towson Funeral Home, Inc. ADDRESS Towson, Maryland   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 24 1983  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Carver  |  |

438

11/2/33

WILLIAM H. HARTSOX



ST. LOUIS, MO.

WILLIAM H. HARTSOX

Cardio Pulmonary Arrest  
Coagulate Heart Failure

X

Robert Thompson MD  
11/2/33



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 0 0 1

REG. NO.

|   |  |  |   |  |                                   |  |  |
|---|--|--|---|--|-----------------------------------|--|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |   | MONTH  | DAY                               | YEAR   | 2b. HOUR                                     |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  | MIDDLE  | LAST   |                                   |  |  |
| LONZIE LEE HARVIN   |  | 1  |   | 10   |                                   | 83   |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                               |  | IF UNDER 1 YEAR                   |  | IF UNDER 24 HRS.                             |
| Male  | Black  | MONTH DAY YEAR   | 76 YRS.   |  | MONTHS DAYS                       |  | HOURS MIN.                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |                                   |  |  |
| South Car.  | USA  |  | Baltimore MD.   |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| Balto.  | 2028 W. Rodgers Ave.   |  | Glass Co.   |  |                                   |  |  |
| 13a. STATE  |  | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?   | 13e. STREET ADDRESS               |  |  |
| Md.   |  |  | Balto.  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 2028 W. Rodgers Ave. 21207        |  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |   | 17. INFORMANT ADDRESS  |                                   |  |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST  |   |  |                                   |  |  |
| Durant  |  | Harvi n  |   | Roxanne  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS  |                                   |  |  |
| No  |  |  |   | Lee Harvin 3208 Windsor Blvd.  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |   |  |                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:  |  |  |   |  |                                   |  |  |
| IMMEDIATE CAUSE (a) <u>cardio-respiratory failure</u>   |  |  |   |  |                                   |  |  |
| 4140 DUE TO, OR AS A CONSEQUENCE OF   |  |  |   |  |                                   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerotic heart disease</u>   |  |  |   |  |                                   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>CCPD</u>  |  |  |   |  |                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |   |  |                                   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                                   |  |  |
|   |  | P.M. 19  |   |  |                                   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |                                   |  |  |
|   |  |  |   |  |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/16</u> , 19 <u>82</u> , to <u>11/16</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>11/16</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |                                   |  |  |
| 22b. SIGNATURE <u>B. C. Thacker</u>   |  |  |   | DEGREE   |                                   | 22c. DATE SIGNED   |  |
|   |  |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                   | 11/11/85   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |   | 22e. ADDRESS   |                                   |  |  |
| B. C. THACKER   |  |  |   |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |                                   | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |
| Burial  |  | 1/14/83  |   | ARBUTUS MEM. PK.   |                                   | BALTO., MD.  |  |
| 24. FUNERAL DIRECTOR NAME   |  |  |   | 25a. DATE REC'D. BY REGISTRAR  |                                   | 25b. REGISTRAR'S SIGNATURE                                     |  |
| LEROY O. DYETT & SON F.H. 4600 LIBERTY HGTS. AVE.   |  |  |   | JAN 11 1983  |                                   | <u>J. Conner</u>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will file a report.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 3 0 1 0 0 2   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>John P. Hawkins</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1 21 83</b>  |  | 2b. HOUR<br><b>105 M</b>  |  |
| 3. SEX<br><b>m</b>   |  | 4. RACE<br><b>l</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>6 29 13</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>69 YRS</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Greensboro, NC</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto. MD</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran Hosp.</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Hunt Valley</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br><b>MD Balto. Balto.</b>   |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>3806 Sequoia Avenue 21215</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Emmanuel Hawkins</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Laura Kearnes</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>YES 1986?</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>214-01-1926</b>  |  | 17. INFORMANT ADDRESS<br><b>Lillian Hawkins-3802 Sequoia Ave.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>5728 IMMEDIATE CAUSE (a) Hepatic Coma</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hepatic Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 week 3 yr</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>None</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>19 80</b> to <b>215 hr</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>20 Jan</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.           |  |   |  |   |  |   |  |
| 22b. SIGNATURE DEGREE<br><b>Louis N. Randall MD</b>  |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>1/21/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Louis N. RANDALL MD</b>  |  |   |  | 22e. ADDRESS<br><b>2300 Garrison Blvd.</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/25/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MD VET CEMETERY -CROWNSVILLE</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Crownsville, MD</b>   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>EROY O. DYETT &amp; SON 4600 Liberty Hghts. Ave.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE<br><b>JAN 24 1983 Joan J. Canfield</b>  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2 and 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 0 0 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |  |   |   |
|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BOBBE KOHUT HAYES</b>                |   |  | 2a. DATE OF DEATH MONTH <b>Jan</b> DAY <b>1/21</b> YEAR <b>1983</b> 2b. HOUR <b>7:12</b> PM |   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH MONTH <b>6</b> DAY <b>15</b> YEAR <b>32</b>   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>50</b> YRS.  | 7. IF UNDER 1 YEAR MONTHS <b>---</b> DAYS <b>---</b> IF UNDER 1 HRS. HOURS <b>---</b> MIN. <b>---</b> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N. Carolina</b>                | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                              |   |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>                                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bunsecours Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST WORKING LIFE) <b>Housewife</b>                 | 12b. KIND OF BUSINESS OR INDUSTRY <b>---</b>  |
| 13a. STATE <b>Maryland</b>  |   | 13b. COUNTY <b>Baltimore</b>   | 13c. CITY OR TOWN <b>Baltimore</b>  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                     |
| 14. FATHER'S NAME FIRST <b>Samuel</b> MIDDLE <b>---</b> LAST <b>Lupton</b>  |   | 15. MOTHER'S MAIDEN NAME FIRST <b>Modonna</b> MIDDLE <b>---</b> LAST <b>Robinson</b>   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b> |   | 16b. SOCIAL SECURITY NO. <b>213-28-0363</b>  |   | 17. INFORMANT ADDRESS <b>Joseph Hayes 1039 Wilmington Avenue 21230</b>                                |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>3030</b> IMMEDIATE CAUSE (a) <b>Cardiac respiratory arrest.</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Heart failure</b><br>(c) <b>Alcoholism.</b>                            |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |

|  |  |   |  |  |   |
|--|--|---|--|--|---|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>12 19 83</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/20</b> , 19 <b>83</b> , to <b>1/21</b> , 19 <b>83</b> , that (I) (we) lost <b>1/21</b> saw the deceased alive at <b>1/21</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |   |
| 22b. SIGNATURE <b>[Signature]</b>  |  | DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <b>Jan 24, 83</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. M. M. M.</b>   |  | 22e. ADDRESS <b>1810 St. Paul St. 21202</b>   |  |  |   |

|  |                          |  |  |
|--|--------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  | 23b. DATE <b>1/25/83</b> | 23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Pk.</b>                                 | 23d. LOCATION CITY OR TOWN <b>Elkridge</b> COUNTY <b>Howard</b> STATE <b>Md.</b> |
| 24. FUNERAL DIRECTOR NAME <b>Hubbard Funeral Home, Inc.</b> ADDRESS <b>4107 Wilkens Ave. 21229</b> |                          | 25a. DATE REC'D. BY REGISTRAR <b>JAN 24 1983</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b> |  |



12

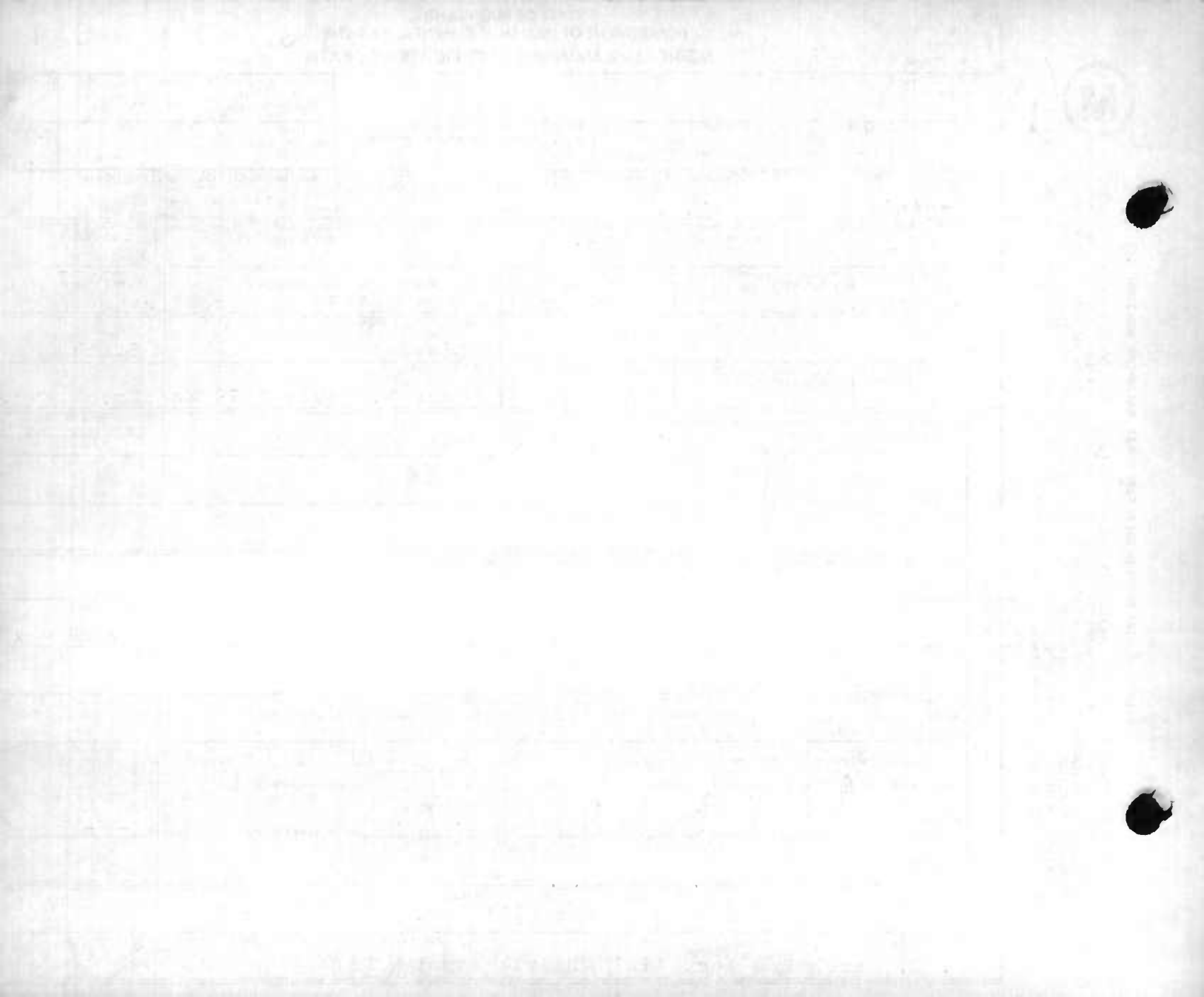


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, RETURN TO THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201. IF THE DEATH IS SUSPECTED, THE CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF THE DEATH IS SUSPECTED, THE CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF THE DEATH IS SUSPECTED, THE CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                  |  |  |  |   |  |   |                        | REG. NO. 3 0 1 0 0 4  |  |
|---|--|------------------|--|--|--|---|--|---|------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>HERBERT HAYES  |  |                  |  |  |  |   |  |   |                        | 2a. DATE KNOWN OF DEATH<br>ESTIMATED MONTH DAY YEAR<br>1-28-83                      |  |
| 3. SEX<br>male  |  | 4. RACE<br>Black |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 1 03   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>80 YRS.                                 |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>1-28-83   |                        | 7b. HOUR<br>PM<br>8:07  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |                        |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Provident Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |                        | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Maryland  |  |                  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                        | 13e. STREET ADDRESS<br>21217 2879 Woodbrook Avenue                                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>N/A   |  |                  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lizzie Stark                 |  |   |                        |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  |                  |  | 16b. SOCIAL SECURITY NO.<br>N/a  |  | 17. INFORMANT ADDRESS<br>Flora M. Davis 2879 WoodBrook Ave.                   |  |   |                        |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF  |  |                  |  |  |  |   |  |   |                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                  |  |  |  |   |  |   |                        |   |  |
| 19a. DATE OF OPERATION  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |                        | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |                        |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |                        |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                  |  |  |  |   |  |   |                        |   |  |
| ACTUAL SIGNATURE<br>Margaret A. Koroll, M.D.  |  |                  |  |  |  | TITLE (SPECIFY)<br>M. Assistant MEDICAL EXAMINER                              |  |   | DATE SIGNED<br>1-29-83 |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Margarita A. Koroll, M.D.  |  |                  |  |  |  | ADDRESS<br>111 Penn Street  |  |   |                        |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL   |  |                  |  | 23b. DATE<br>2/2/83  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cem.                         |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Glenburnie Md                                     |                        |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Wm. C. March F/h Inc. 1101 E. North Avenue  |  |                  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 31 1983                                  |  | REGISTRAR'S SIGNATURE<br>J. A. G. Carver  |                        |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |                     |  | 8 3 0 1 0 0 5   |     |                                   |  |
|--|--|--|--|---|--|---|--|---------------------|--|---|-----|-----------------------------------|--|
| 1- FOR STATE REGISTRAR   |  | REG. NO.   |  |   |  |   |  |                     |  |   |     |                                   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH   |  | MONTH   | DAY | YEAR                              | 2b. HOUR                                     |
| ADA  |  |  |  |   |  | HAYNES  |  | JAN 27, 1983        |  |   |     |                                   | 8 <sup>30</sup> A.M.                         |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR  |  | 8. IF UNDER 73 HRS.   |     |                                   |  |
| Female   |  | White  |  | MONTH DAY YEAR<br>2 19 1907   |  | 75 YRS.   |  | MONTHS DAYS         |  | HOURS MIN.  |     |                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                     |  |   |     |                                   |  |
| Virginia   |  | U.S.A.   |  |   |  | Baltimore City MD.  |  |                     |  |   |     |                                   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |   |  |                     |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |     | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| BALTO CITY   |  | MFL Nursing Home, B.C.H.   |  |   |  |   |  |                     |  | Housewife   |     | Domestic                          |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS |  | 13f. ZIP CODE   |     |                                   |  |
| Maryland   |  | Baltimore  |  | Dundalk   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 2016 Wareham Avenue |  | 21222   |     |                                   |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |  |                     |  |   |     |                                   |  |
| FIRST MIDDLE LAST<br>Elliott Arnold  |  | FIRST MIDDLE LAST<br>Mary Ellen Pendergrast  |  |   |  |   |  |                     |  |   |     |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT   |  | ADDRESS   |  |                     |  |   |     |                                   |  |
| No   |  | 226-22-8843  |  | Carl Haynes   |  | 2016 Wareham Avenue<br>Dundalk, Maryland                            |  |                     |  |   |     |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |  |   |  |                     |  |   |     |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |   |  |   |  |                     |  |   |     |                                   |  |
| 4275 IMMEDIATE CAUSE (a) Cardiorespiratory Arrest  |  |  |  |   |  |   |  |                     |  |   |     |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |   |  |                     |  |   |     |                                   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |   |  |   |  |                     |  |   |     |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |   |  |                     |  |   |     |                                   |  |
| (c)  |  |  |  |   |  |   |  |                     |  |   |     |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a   |  |  |  |   |  |   |  |                     |  |   |     |                                   |  |
| multiple strokes; multiple pressure sores  |  |  |  |   |  |   |  |                     |  |   |     |                                   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                     |  |   |     |                                   |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                     |  |   |     |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |                     |  |   |     |                                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |                     |  |   |     |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 20 Aug 82, 1982, to 27 Jan 83, that (I) (we) last saw the deceased alive on 27 Jan 83, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |                     |  |   |     |                                   |  |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED  |  |   |  |                     |  |   |     |                                   |  |
| Edmunds Beacham MD   |  |  |  | 27 Jan 83   |  |   |  |                     |  |   |     |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |   |  |   |  |                     |  |   |     |                                   |  |
| E.G. BEACHAM M.D.  |  | BALTIMORE CITY HOSPITALS   |  |   |  |   |  |                     |  |   |     |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |                     |  |   |     |                                   |  |
| Burial   |  | 1-31-83  |  | Cecil Cemetery  |  | Pennington Gap, Lee, Virginia                                       |  |                     |  |   |     |                                   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS  |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |                     |  |   |     |                                   |  |
| Marzullo Funeral Service Reisterstown, Md.   |  |  |  | JAN 31 1983   |  | John J. [Signature]   |  |                     |  |   |     |                                   |  |

2001.5.14

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  | 8301006  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME   |  |  |  |  |  |  |  |  |  | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Marie A. Healy</b>   |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 1 26 83   |  |
| 3. SEX <b>F Female</b>   |  |  |  |  |  |  |  |  |  | 2b. HOUR 450 AM  |  |
| 4. RACE <b>E White</b>   |  |  |  |  |  |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 84   |  |
| 5. DATE OF BIRTH MONTH DAY YEAR 8 7 98   |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>  |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.   |  |
| 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>   |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Bookkeeper</b>  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mercy Hospital</b> |  |
| 13a. STATE <b>Md.</b>  |  |  |  |  |  |  |  |  |  | 13b. COUNTY <b>Baltimore</b>   |  |
| 13c. CITY OR TOWN <b>Baltimore</b>   |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Lawrence De Barber</b>  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Katherine Reppetto</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO. <b>171-07-7922</b>  |  |
| 17. INFORMANT ADDRESS <b>Herbert Yingling 4702 Morello Road 21214</b>  |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypotension</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Refractory heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Respiratory failure, Myocardial Infarction, Ischemic Heart Disease</b> |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a   |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |  |  |  |  | 21d. INJURY OCCURRED   |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  |  |  |  |  |  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 20, 1982</b> to <b>Jan 26, 1983</b> , that (I) (we) lost <b>saw the deceased alive on Jan 26, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                    |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED <b>1/26/83</b>  |  |
| 22b. SIGNATURE <b>Donald M. Lai</b> DEGREE <b>MD</b>   |  |  |  |  |  |  |  |  |  | 22d. ADDRESS <b>Mercy Hospital</b>   |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Donald M. Lai</b>   |  |  |  |  |  |  |  |  |  | 22f. ADDRESS <b>Mercy Hospital</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |  |  |  |  |  |  |  |  | 23b. DATE <b>Jan. 29, 1983</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>   |  |  |  |  |  |  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Altoona Pennsylvania</b>  |  |
| 24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc. Baltimore, Maryland</b> ADDRESS   |  |  |  |  |  |  |  |  |  | 25a. DATE RECD. BY REGISTRAR <b>JAN 27 1983</b>  |  |
| 25b. REGISTRAR'S SIGNATURE <b>Leonard J. Ruck</b>  |  |  |  |  |  |  |  |  |  |  |  |

Leonard J. Smith, Inc., Baltimore, Maryland

Period: Jan. 1, 1967, Calvary Cemetery

Illinois

Remains of

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |  |  | 8301007  |  |
|---|--|---|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |  |  |  |  |  |  | REG. NO.                                       |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ALTON JOSEPH HEATH</b>   |  |   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-4-83</b>   |  | 2b. HOUR<br><b>2:45 PM</b>   |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>03 05 10</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>72</b>   |  | 8. IF UNDER 74 HRS<br>HOURS MIN.<br><b>245</b> |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 10. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 12. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                             |  |  |  |  |  |
| 13. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>John L. Dedmon Medical Center</b> |  |  |  | 15. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>NURSE</b>                |  | 16. KIND OF BUSINESS OR INDUSTRY<br><b>NURSING</b>   |  |  |  |
| 17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>MARYLAND</b>   |  | 18. COUNTY<br><b>BALTIMORE</b>  |  | 19. CITY OR TOWN<br><b>ARBUTUS</b>   |  | 20. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 21. STREET ADDRESS<br><b>4400 ALAN DRIVE APT. C 21229</b>  |  |  |  |
| 22. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HARLEY HEATH</b>   |  |   |  | 23. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY UNKNOWN</b>   |  |  |  |  |  |  |  |
| 24. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 25. (IF YES, GIVE WAR OR DATES)   |  | 26. SOCIAL SECURITY NO.<br><b>219-07-9620</b>  |  | 27. INFORMANT<br><b>VIRGINIA HEATH</b>   |  | 28. ADDRESS<br><b>4400 ALAN DRIVE APT. C 21229</b>   |  |  |  |
| 29. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4360 IMMEDIATE CAUSE (a) Cardio-Pulmonary Arrest</b>  |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Cerebral aneurysm Accident</b>   |  |   |  |  |  |  |  |  |  | ~1 year  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Multiple decubitus ulcers</b>  |  |   |  |  |  |  |  |  |  | ~1 year  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Chronic Foley catheter / Gastrostomy tube / chronic atrial fibrillation</b>  |  |   |  |  |  |  |  |  |  |  |  |
| 30. DATE OF OPERATION   |  | 31. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 32. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 33. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                      |  |  |  |
| 34. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 35. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 36. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |  |  |
| 37. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 38. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 39. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
| 40. I certify that (I) (this hospital) attended the deceased from <b>4/19</b> , 19 <b>82</b> , to <b>1/4</b> , 19 <b>83</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/4</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |  |  |  |  |
| 41. SIGNATURE<br><b>David W. McClure MD</b>   |  |   |  | 42. DEGREE<br><b>MD</b>  |  |  |  | 43. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 44. DATE SIGNED<br><b>1/4/83</b>               |  |
| 45. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DAVID W. McClure MD</b>  |  |   |  | 46. ADDRESS<br><b>611 S. Charles St. Balt. Md. 21230</b>   |  |  |  |  |  |  |  |
| 47. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 48. DATE<br><b>01-07-83</b>   |  | 49. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>  |  | 50. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b>                    |  |  |  |  |  |
| 51. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>   |  |   |  | 52. ADDRESS<br><b>4107 WILKENS AVE.</b>  |  | 53. DATE REC'D. BY REGISTRAR<br><b>JAN 7 1983</b>  |  | 54. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>   |  |  |  |

BP



CHINA

2000





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMM - 16 50M 4/82  
(VRA 15, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |             |   |                                       |  |   |  |   |  |
|--|--|---|-------------|---|---------------------------------------|--|---|--|---|--|
| 8 3 0 1 0 0 8  |  |   |             |   |                                       |  |   |  |   |  |
| 1. FOR STATE REGISTRAR   |  |   |             |   |                                       |  |   |  |   |  |
| REG. NO.   |  |   |             |   |                                       |  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Percy A. Heath, Sr.</b>   |  |   |             |   |                                       | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 27, 1983</b>                       |   | 2b. HOUR<br><b>M</b>   |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>   |             | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 4 1931</b>  |                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>51</b> YRS.                                    |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |             | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1637 E. North Avenue 3rd Fl</b> |             |   |                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE<br><b>MD</b>  |  |   | 13b. COUNTY |   | 13c. CITY OR TOWN<br><b>Baltimore</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3rd Fl 21213<br/>1637 E. North Avenue</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Heath</b>  |  |   |             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie Sample</b>  |                                       |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  |   |             | 16b. SOCIAL SECURITY NO.<br><b>229-38-9226</b>  |                                       | 17. INFORMANT<br>ADDRESS<br><b>Mary M. Heath 1637 E. North Ave. 3rd Floor</b>        |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4100</b> IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Coronary Arteriosclerotic Heart Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>Hypertension</b> |  |   |             |   |                                       |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.  |  |   |             |   |                                       |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |             |   |                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                       |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                       |  |   |  |   |  |
| 22a. I certify that (I) <del>XXXXXX</del> attended the deceased from <b>October</b> , 19 <b>1977</b> , to <b>November</b> , 19 <b>82</b> , that (I) <del>XXXXXX</del> saw the deceased alive on <b>Nov. 28</b> , 19 <b>82</b> , and that in (my) <del>XXXXXX</del> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |             |   |                                       |  |   |  |   |  |
| 22b. SIGNATURE<br><i>[Signature]</i>   |  | 22c. ADDRESS<br><b>922 W. North Avenue<br/>Baltimore, Maryland 21217</b>  |             |   |                                       | 22d. DATE SIGNED<br><b>1/27/83</b>   |   |  |   |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ARCHIE ROBINSON, JR., M.D.</b>   |  | 22f. ADDRESS  |             | 22g. DATE REC'D. BY REGISTRAR<br><b>JAN 28 1983</b>   |                                       | 22h. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                     |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>1/31/83</b>   |             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Veteran Cem.</b>   |                                       | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crownsville Md.</b>                 |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E. North Ave.</b>   |  |   |             |   |                                       | 25. DATE REC'D. BY REGISTRAR<br><b>JAN 28 1983</b>                                   |   |  |   |  |



UNITED STATES GOVERNMENT  
DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

JOHN S. BOSS  
JAN 28 1963

Item 13e per phone 1/26/83 dad STATE OF MARYLAND  
 1- FOR  
 STATE  
 REGISTRAR  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

|  |                    |   |  |  |  |
|--|--------------------|---|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>THELMA MAE HEBRON</b>  |                    |   | 2a DATE OF DEATH<br>MONTH DAY YEAR <b>1-16-83</b>                                      |  | 2b HOUR<br><b>6 AM</b>                       |
| 3 SEX<br><b>F</b>  | 4 RACE<br><b>B</b> | 5 DATE OF BIRTH<br>MONTH DAY YEAR <b>11 27 30</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>52</b> YRS  |  |
| 7a BIRTHPLACE<br>STATE OR FOREIGN COUNTRY <b>MD</b>  |                    | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY</b>  |                    |   | 10 USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Board Education</b>  |  |  |
| 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. AGNES Hosp.</b>  |                    |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Board Education</b> |  |  |
| 13a CITY OR TOWN OF DEATH<br><b>BALTO.</b>   |                    |   | 13b KIND OF BUSINESS OR INDUSTRY   |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST <b>JOHN HENRY Matthews</b>   |                    |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Amy JOHNSON</b>                        |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |                    |   | 16b SOCIAL SECURITY NO.<br><b>215-32-4057</b>  |  |  |
| 17 INFORMANT<br><b>Wm. B. HEBRON</b>   |                    |   | ADDRESS<br><b>7102 Wright Rd HANOVER MD</b>  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart failure (Cardiac arrest)</b><br>1991<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>metastatic adenoca</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |                    |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes mellitus, hypertension, glaucoma</b>   |                    |   |  |  |  |
| 19a DATE OF OPERATION  |                    | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                    | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                    | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR <b>12 28 82</b>  |  | 21c HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                    | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>12-28-82</b> 19 <b>82</b> , to <b>1-16-83</b> 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>1-15-83</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                            |                    |   |  |  |  |
| 22b SIGNATURE<br><b>Purushottam mitra</b>  |                    | DEGREE  |  | 22c DATE SIGNED<br><b>1-16-83</b>  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PURUSHOTTAM MITRA</b>   |                    | 22e ADDRESS<br><b>ST. AGNES HOSPITAL</b>  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |                    | 23b DATE<br><b>1/20/83</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Catholic mem PR</b>  |  |
| 23d LOCATION<br>(CITY OR TOWN) <b>Baltimore</b>  |                    | 23e LOCATION<br>(CITY OR TOWN) <b>Baltimore</b>   |  | 23f LOCATION<br>(CITY OR TOWN) <b>Baltimore</b>  |  |
| 24 FUNERAL DIRECTOR<br>NAME <b>Locke Funeral Home</b>  |                    | 24b ADDRESS<br><b>1304 N. Central St</b>  |  | 25a DATE REC'D. BY REGISTRAR<br><b>JAN 19 1983</b>   |  |
| 25b REGISTRAR'S SIGNATURE<br><b>John J. Casper</b>   |                    |   |  |  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 0 1 0

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |  |  |  |  |  |
|---|--|--|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Pearl - Helmholz</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 1, 1983</b> |   |  | 2b. HOUR<br>M<br><b>M</b>  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 28, 1898</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Italy</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b>                                  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4408 Cook Avenue</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>4408 Cook Avenue 21204</b>                                 |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Cicero - Richitelli</b>  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Constantina -</b>   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>212-28-0321</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Mr. Hugo W. Helmholz Sr. 237 Walgrove Rd. Reisterstown, Md.</b>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Standstill</b><br><b>2500</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes</b> |  |  |   |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>  |  |  |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Samuel Stern MD</b>  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  |  |  | 22c. DATE SIGNED<br><b>1/3/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Samuel Stern MD</b>   |  |  |   | 22e. ADDRESS<br><b>6918 Ridge Road Baltimore, Maryland</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Entombment</b>   |  | 23b. DATE<br><b>Jan. 4, 1983</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crest Lawn</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Sykesville Carroll Md.</b>          |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck Inc. Baltimore, Maryland</b>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>10N 4 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                                  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1948 1949 1950 1951 1952 1953 1954 1955 1956 1957 1958 1959 1960 1961 1962 1963 1964 1965 1966 1967 1968 1969 1970 1971 1972 1973 1974 1975 1976 1977 1978 1979 1980 1981 1982 1983 1984 1985 1986 1987 1988 1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 2330 2331 2332 2333 2334 2335 2336 2337 2338 2339 2340 2341 2342 2343 2344 2345 2346 2347 2348 2349 2350 2351 2352 2353 2354 2355 2356 2357 2358 2359 2360 2361 2362 2363 2364 2365 2366 2367 2368 2369 2370 2371 2372 2373 2374 2375 2376 2377 2378 2379 2380 2381 2382 2383 2384 2385 2386 2387 2388 2389 2390 2391 2392 2393 2394 2395 2396 2397 2398 2399 2400 2401 2402 2403 2404 2405 2406 2407 2408 2409 2410 2411 2412 2413 2414 2415 2416 2417 2418 2419 2420 2421 2422 2423 2424 2425 2426 2427 2428 2429 2430 2431 2432 2433 2434 2435 2436 2437 2438 2439 2440 2441 2442 2443 2444 2445 2446 2447 2448 2449 2450 2451 2452 2453 2454 2455 2456 2457 2458 2459 2460 2461 2462 2463 2464 2465 2466 2467 2468 2469 2470 2471 2472 2473 2474 2475 2476 2477 2478 2479 2480 2481 2482 2483 2484 2485 2486 2487 2488 2489 2490 2491 2492 2493 2494 2495 2496 2497 2498 2499 2500 2501 2502 2503 2504 2505 2506 2507 2508 2509 2510 2511 2512 2513 2514 2515 2516 2517 2518 2519 2520 2521 2522 2523 2524 2525 2526 2527 2528 2529 2530 2531 2532 2533 2534 2535 2536 2537 2538 2539 2540 2541 2542 2543 2544 2545 2546 2547 2548 2549 2550 2551 2552 2553 2554 2555 2556 2557 2558 2559 2560 2561 2562 2563 2564 2565 2566 2567 2568 2569 2570 2571 2572 2573 2574 2575 2576 2577 2578 2579 2580 2581 2582 2583 2584 2585 2586 2587 2588 2589 2590 2591 2592 2593 2594 2595 2596 2597 2598 2599 2600 2601 2602 2603 2604 2605 2606 2607 2608 2609 2610 2611 2612 2613 2614 2615 2616 2617 2618 2619 2620 2621 2622 2623 2624 2625 2626 2627 2628 2629 2630 2631 2632 2633 2634 2635 2636 2637 2638 2639 2640 2641 2642 2643 2644 2645 2646 2647 2648 2649 2650 2651 2652 2653 2654 2655 2656 2657 2658 2659 2660 2661 2662 2663 2664 2665 2666 2667 2668 2669 2670 2671 2672 2673 2674 2675 2676 2677 2678 2679 2680 2681 2682 2683 2684 2685 2686 2687 2688 2689 2690 2691 2692 2693 2694 2695 2696 2697 2698 2699 2700 2701 2702 2703 2704 2705 2706 2707 2708 2709 2710 2711 2712 2713 2714 2715 2716 2717 2718 2719 2720 2721 2722 2723 2724 2725 2726 2727 2728 2729 2730 2731 2732 2733 2734 2735 2736 2737 2738 2739 2740 2741 2742 2743 2744 2745 2746 2747 2748 2749 2750 2751 2752 2753 2754 2755 2756 2757 2758 2759 2760 2761 2762 2763 2764 2765 2766

VOIDED DEATH CERTIFICATE NUMBER 83-01011

SEE DECEMBER, 1982 - BABY BOY HENSON,

DIED: OCT. 3, 1982 - CITY

SEE LATE 1982's





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

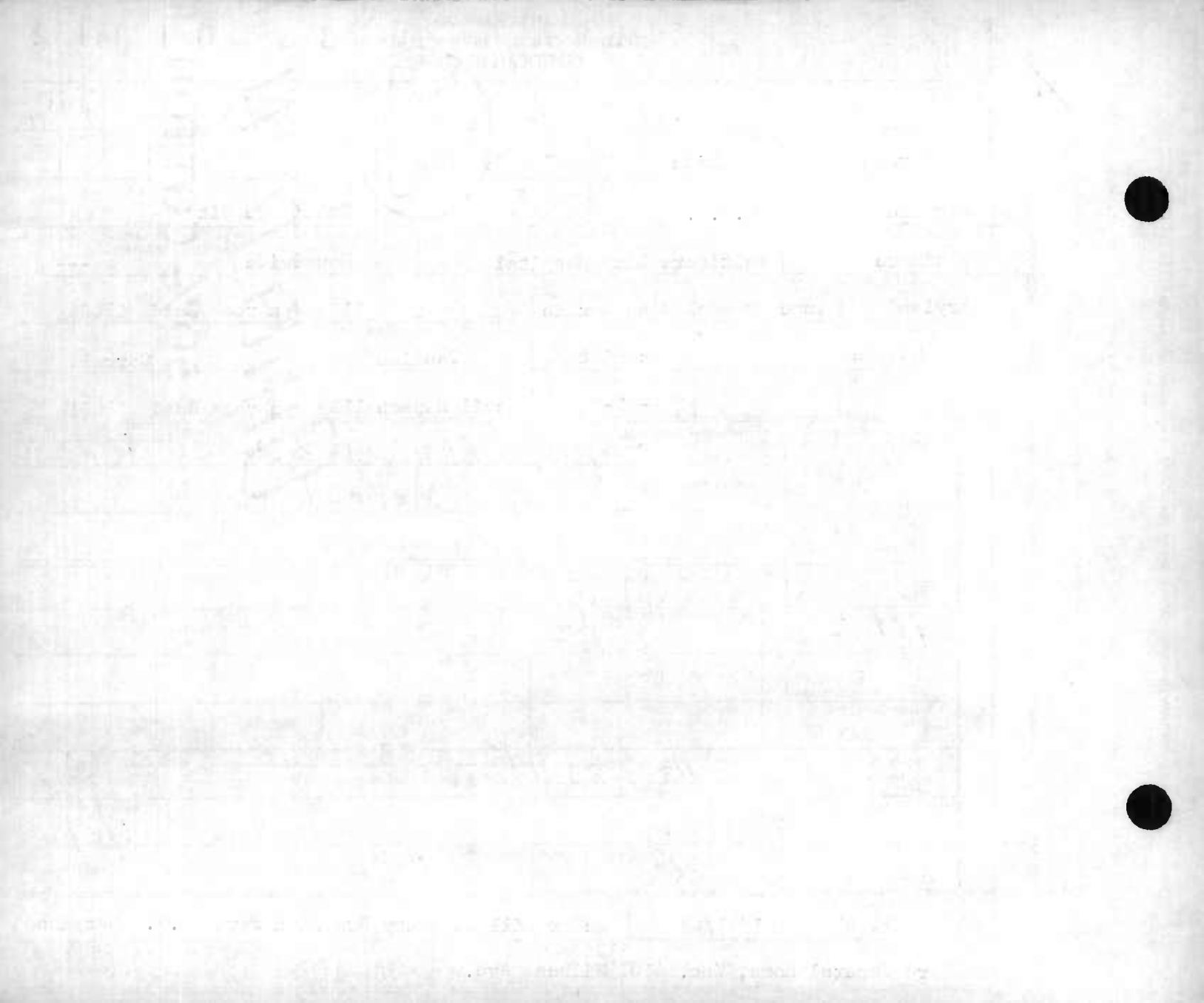
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report obtained.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |   |   |  |   | 8  | 3   | 0  | 1  | 0                                 | 1 | 2 |
|--|--|--|--|--|--|---|---|--|---|--|---|--|--|-----------------------------------|---|---|
| 1- FOR STATE REGISTRAR   |  |  |  |  |  |   |   |  |   | REG. NO.   |   |  |  |                                   |   |   |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>JANE L. HENSON  |  |  |  |  |  |   |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1/8/83                                  |   |  |  | 2b. HOUR<br>1:40 PM               |   |   |
| 3. SEX<br>Female   |  |  | 4. RACE<br>White   |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 29 44   |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>38 YRS.  |  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  | 8. IF UNDER 24 HRS.<br>HOURS MIN. |   |   |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |   |  |  |                                   |   |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospital |  |  |   |   |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>--- |                                   |   |   |
| 13a. STATE<br>Maryland   |  |  | 13b. COUNTY<br>Anne Arundel  |  |  | 13c. CITY OR TOWN<br>Glen Burnie  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>1109 Wynbrook Road 21061 |  |  |                                   |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Schmidt   |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Pauline Carroll       |   |   |  |   |  |   |  |  |                                   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-42-3497 |   |   |  |   | 17. INFORMANT<br>ADDRESS<br>Cecil Henson 1109 Wynbrook Road 21061              |   |  |  |                                   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>0545 IMMEDIATE CAUSE (a) Sepsis, CPM arrest x 2<br>DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis / Met. acidosis<br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (c) Cytomegalovirus, systemic?<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 minutes |  |  |  |  |  |   |   |  |   |  |   |  |  |                                   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a<br>slp Renal Transplant.  |  |  |  |  |  |   |   |  |   |  |   |  |  |                                   |   |   |
| 19a. DATE OF OPERATION<br>10/2/82  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>CRF                |   |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                   |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |  |  |                                   |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |   |   |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |                                   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/8/83 to 1/8/83, that (I) (we) last saw the deceased alive on 1/8/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |   |  |   |  |   |  |  |                                   |   |   |
| 22b. SIGNATURE<br>Greenberg  |  |  |  |  |  |   |   |  |   | DEGREE   |   | 22c. DATE SIGNED<br>1/8/83   |  |                                   |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MARTIN GREENBERG  |  |  |  |  |  |   |   |  |   | 22e. ADDRESS<br>BCH.   |   |  |  |                                   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  |  |  | 23b. DATE<br>1/11/83   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brooklyn Park A.A. Maryland      |   |  |  |                                   |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.   |  |  |  |  |  |   |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 10 1983                                   |   | 25b. REGISTRAR'S SIGNATURE<br>John J. Carver   |  |                                   |   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be called in.

MEDICAL CERTIFICATION

| 1- FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  | 8 3 0 1 0 1 3  |   | REG. NO.   |  |
|--|--|---|--|--|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>MARTE Elizabeth HERMAN   |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 1 13 83<br>2b. HOUR 12:55 PM  |  |   |  |  |
| 3 SEX F  |  | 4 RACE White  |  | 5. DATE OF BIRTH MONTH DAY YEAR 7 29 1895  |  | 6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS.                 |   | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. |   |  |  |
| 10. CITY OR TOWN OF DEATH Balto.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN<br>Md. Balto.   |  |   |  |  | 13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13c. STREET ADDRESS Balto., Md. 21207<br>11-C West Bend Ct.   |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Henry Tribbe   |  |   |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary Buxmeier   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |   |  |  | 16b. SOCIAL SECURITY NO. 579-62-9573   |  |   |  |  |
| 17a. DECEASED ADDRESS 2504 E. Meredith Dr., Vienna, Va.  |  |   |  |  | 17b. DECEASED ADDRESS 22180  |  |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) Severe Congestive Heart Failure<br>DUE TO, OR AS A CONSEQUENCE OF (b) Advancement of the cardiovascular disease<br>DUE TO, OR AS A CONSEQUENCE OF (c) —<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months<br>4 years |  |   |  |  |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Cardiac arrhythmia.   |  |   |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION No  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None   |  |  | 19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-20-1982 to 1-13-1983, that (I) (we) last saw the deceased alive on 1-13-1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |  |   |  |  |
| 22b. SIGNATURE George J. Vellani Karan   |  |   |  |  | DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED 1-13-83  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. VELLANIKAR AN MD  |  |   |  |  | 22e. ADDRESS St. Agnes Hospital, Baltimore MD-21228  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  | 23b. DATE 1-17-83   |  | 23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem. Arlington, Va.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                |   |  |  |
| 24. FUNERAL DIRECTOR G. Truman Schwab 5151 Balto. Nat'l. Pike #21229   |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR JAN 18 1983  |  |   |  |  |
|  |  |   |  |  | 25b. REGISTRAR'S SIGNATURE John J. Casier  |  |   |  |  |

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Items #18a-22a Film G577 3/3/83 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8 3 0 1 0 1 4

|  |         |   |                   |  |                  |   |  |                          |  |
|--|---------|---|-------------------|--|------------------|---|--|--------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST MIDDLE LAST   |                   | 2a. DATE KNOWN OF DEATH  |                  | MONTH DAY YEAR  |  | 2b. HOUR                 |  |
| JULIA Elizabeth  |         | HERNDON   |                   | ESTIMATED  |                  | 1-5-83  |  | 19                       |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  | 6. AGE (IN YEARS) | IF UNDER 1 YR.   | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD  |  | 2d. HOUR                 |  |
| Female   | White   | July 3, 1941  | 41 YRS.           | MONTHS   | DAYS             | 1-5-83  |  | 9:51                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?  |                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                          |  |
| Maryland   |         | USA   |                   |  |                  | Baltimore City  |  |                          |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |                  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                          |  |
| Baltimore  |         | 911 W. Lake Avenue  |                   | Nurse's Aid  |                  | Nursing   |  |                          |  |
| 13a. STATE   |         | 13b. COUNTY   |                   | 13c. CITY OR TOWN  |                  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS      |  |
| Md   |         | -   |                   | Baltimore  |                  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 911 W. Lake Avenue 21210 |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME  |                   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |                  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS    |  |
| Harry R. Herndon   |         | Irene Montgomery  |                   | no   |                  | 215 40 1434   |  | Harry R. Herndon same    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  |         |   |                   |  |                  |   |  |                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |   |                   |  |                  |   |  |                          |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                   |  |                  | 20. AUTOPSY?  |  |                          |  |
|  |         |   |                   |  |                  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                  |   |  |                          |  |
|  |         | P.M. 19   |                   |  |                  |   |  |                          |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |                   | 21f. LOCATION CITY OR TOWN COUNTY STATE  |                  |   |  |                          |  |
|  |         |   |                   |  |                  |   |  |                          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |   |                   |  |                  |   |  |                          |  |
| ACTUAL SIGNATURE   |         | TITLE (SPECIFY)   |                   |  |                  | DATE SIGNED   |  |                          |  |
| <i>H. Guard</i>  |         | Assistant   |                   |  |                  | 1-6-83  |  |                          |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         | ADDRESS   |                   |  |                  |   |  |                          |  |
| Hormoz R. Guard, M.D.  |         | 111 Penn Street   |                   |  |                  |   |  |                          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE   |                   | 23c. NAME OF CEMETERY OR CREMATORY   |                  | 23d. LOCATION   |  |                          |  |
| Burial   |         | 1/8/83  |                   | Lorraine Park Cemetery   |                  | Baltimore County Maryland   |  |                          |  |
| 24. FUNERAL DIRECTOR NAME  |         | ADDRESS   |                   | 25a. DATE REC'D. BY REGISTRAR  |                  | 25b. REGISTRAR'S SIGNATURE  |  |                          |  |
| Burgee Funeral Home  |         | 3631 Falls Road 21211   |                   | JAN 11 1983  |                  | <i>John J. [Signature]</i>  |  |                          |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR OFFICE. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



14 Nov 5, 1941

14 Nov 5, 1941

14 Nov 5, 1941

14 Nov 5, 1941



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOUR RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                          |  |   |  |  |  |   |                  | REG. NO. 8 3 0 1 0 1 5  |  |
|--|--|--------------------------|--|---|--|--|--|---|------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>EILEEN Elizabeth HEROLD</b>   |  |                          |  |   |  |  |  |   |                  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1 9 19 83</b> |  |
| 3. SEX <b>Female</b>   |  | 4. RACE <b>Caucasian</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>December 26 1928</b>  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY MONTHS DAYS HOURS MIN <b>54 YRS.</b>                              |  | 7c. DATE PRONOUNCED DEAD <b>1 9 19 83</b>   |                  | 2d. HOUR <b>10:15</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Indiana</b>   |  |                          |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>                                  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |                          |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>  |                  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>   |  |
| 13a. STATE <b>Maryland</b>   |  |                          |  | 13b. COUNTY <b>Baltimore</b>  |  | 13c. CITY OR TOWN <b>Randallstown</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                  | 13e. STREET ADDRESS <b>Randallstown, MD 133<br/>3556 Carriage Hill Circle T4</b>            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>unknown</b>  |  |                          |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>unknown</b>   |  |   |                  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>NO</b>  |  |                          |  | 16b. SOCIAL SECURITY NO. <b>---</b>   |  | 17. INFORMANT <b>Randallstown, Md 21133 T4<br/>Donald H. Herold 3556 Carriage Hill Circle</b>        |  |   |                  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>9550 IMMEDIATE CAUSE (a) Gunshot wound of head (handgun)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                          |  |   |  |  |  |   |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |                          |  |   |  |  |  |   |                  |   |  |
| 19a. DATE OF OPERATION   |  |                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |                  | 20. AUTOPSY<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                          |  | 21b. TIME OF INJURY<br>HOUR <b>8 P.M.</b> MONTH DAY YEAR <b>1-9- 19 83</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Self-inflicted.</b> |  |   |                  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK  |  |                          |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE <b>3556 Carriage Hill Circle Balto. Md.</b>        |  |   |                  |   |  |
| 22a. I certify that I took charge of the remains described above and in my opinion death resulted from: <input type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                                      |  |                          |  |   |  |  |  |   |                  |   |  |
| ACTUAL SIGNATURE <b>Thomas D. Smith</b>  |  |                          |  |   |  | TITLE (SPECIFY) <b>Deputy Chief</b>  |  |   | MEDICAL EXAMINER |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>   |  |                          |  |   |  | ADDRESS <b>111 Penn St., Balto., Md. 21201</b>   |  |   |                  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>   |  |                          |  | 23b. DATE <b>January 13, 1983</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Crematory</b>                                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>  |                  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Loring Byers</b><br>ADDRESS <b>8728 Liberty Rd. Randallstown, MD 21133-4784</b>  |  |                          |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 17 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>   |                  |   |  |

RECEIVED BY THE DIRECTOR  
OF THE BUREAU OF THE ARMY  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |   |   |  |                                   |
|--|--|---|--|---|--|---|---|---|--|-----------------------------------|
| 1. FOR STATE REGISTRAR   |  |   |  |   | REG. NO.   |   |   |   |  |                                   |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Norman L. Herold   |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>January 15, 1983             |   |   |   |  | 2b. HOUR<br>10 <sup>05</sup> P.M. |
| 3. SEX<br>Male   |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>1 - 2 - 1909   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 4 YRS.                                      |   | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                        |   |   |  |                                   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Good Samaritan Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired          |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>BOROZINS INC.  |  |                                   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE<br>MD  |  |   |  |   | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>Baltimore          |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>GEORGE HEROLD   |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>KATHERINE BLESSING |   |   |   |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>YES W.W.II  |  |   |  |   | 16b. SOCIAL SECURITY NO.<br>215-09-0568                          |   | 17. INFORMANT ADDRESS<br>FAMILY RECORDS |   |  |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest<br>1629 DUE TO, OR AS A CONSEQUENCE OF (b) Small cell Carcinoma of the Lung<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) with Metastasis to Brain + Bone<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |   |   |   |  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br>Gastrointestinal Bleeding  |  |   |  |   |  |   |   |   |  |                                   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |   |   |  |                                   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |   |   |  |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-4, 1983, to 1-15, 1983, that (I) (we) last saw the deceased alive on 1-15, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |   |   |  |                                   |
| 22b. SIGNATURE (Signature)<br>Rakesh Sahni   |  |   |  | DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |   | 22c. DATE SIGNED<br>11/15/83  |  |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Rakesh Sahni  |  |   |  | 22e. ADDRESS<br>2713. Oldwood Dr, Falls Church, VA 22043  |  |   |   |   |  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>Jan. 19, 1983  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Mem. Pk.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>PARKVILLE BALTO. MO.                   |   |   |  |                                   |
| 24. FUNERAL DIRECTOR NAME<br>EVAN'S FUNERAL CHAPEL   |  |   |  | ADDRESS<br>8800 Hartford Rd   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 18 1983                                      |   | 25b. REGISTRAR'S SIGNATURE<br>(Signature)   |  |                                   |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |                               |
|---|--|---|--|---|-------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LOUIS HEYMAN</b>                                 |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JANUARY 8, 1983</b>                           |   | 2b. HOUR<br><b>1:40PM</b>     |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br><b>OCT. 20, 1904<sup>AR</sup></b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b>   | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>RUSSIA</b>                                      | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. <b>BALTIMORE CITY</b> OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.             |   |                               |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>TAILOR</b>    | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SCHOENEMAN CO.</b>                        |                               |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |   |  |   |                               |
| 13a. STATE<br><b>MARYLAND</b>   | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>6921 MARSUE DR. APT. 2A (21215)</b>                     |                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HERSCHEL HEYMAN</b>                        |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MOLLIE UNKNOWN</b>  |  |   |                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>       |  | 16b. SOCIAL SECURITY NO.<br><b>214-01-2355</b>  |  | 17. INFORMANT ADDRESS<br><b>MRS. SADIE HEYMAN (21215) 6921 MARSUE DR, APT. 2A</b> |                               |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Acute myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Arteriosclerotic Cardiovascular disease</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>hrs</b><br><b>yrs</b> |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

|   |  |  |  |
|---|--|--|--|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/22</b> 19 <b>82</b> to <b>1/8</b> 19 <b>83</b> , that (I) (we) lost<br>saw the deceased alive on <b>11/22</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><b>R Friedman</b>   | DEGREE<br><b>MD</b>  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br><b>1/10/83</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RONALD FRIEDMAN</b>   |  | 22e. ADDRESS<br><b>6715 PARK HEIGHTS AVE. BALTIMORE, MD (21215)</b>  |  |

|   |                             |  |   |
|---|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>  | 23b. DATE<br><b>1/10/83</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WORKMENS CIRCLE</b> | 23d. LOCATION<br><b>BALTIMORE, MD.</b> COUNTY STATE |
| 24. FUNERAL DIRECTOR<br>NAME <b>SOL LEVINSON &amp; BROS.</b><br>ADDRESS <b>6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)</b> |                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 12 1983</b>          | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>    |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advised.



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U. S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D. C.

CHIEF

100% COTTON

MADE IN U.S.A.

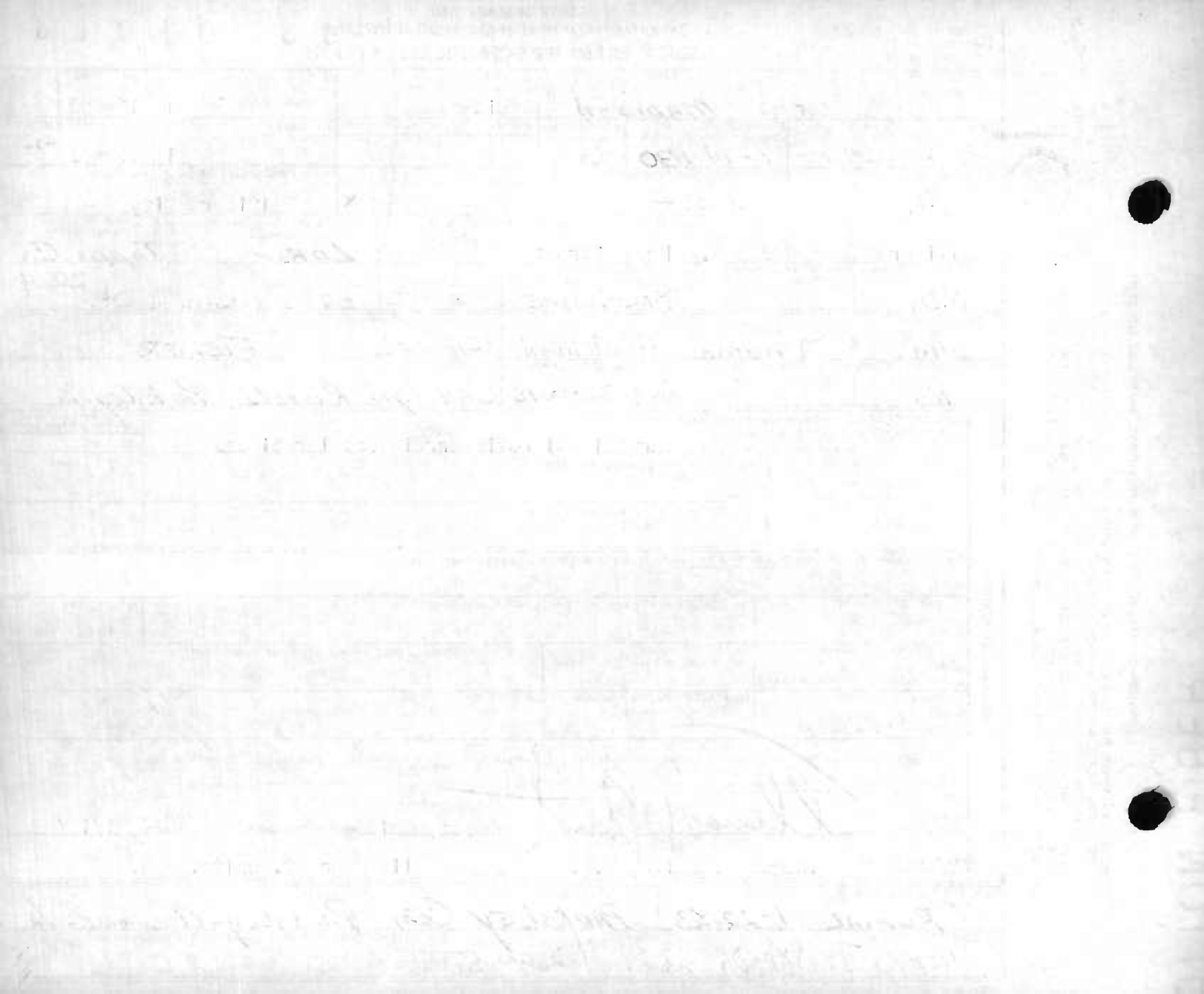
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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(VR A15 ME (5))  
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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |              |   |   |  |   |  |  |  |  | REG. NO. 01018                               |  |
|--|--------------|---|---|--|---|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) George MADISON Hickman   |              |   |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 16 19 83 |  | 2b. HOUR 4:20 PM   |  |  |
| 3. SEX M   | 4. RACE CAU. | 5. DATE OF BIRTH<br>MONTH DAY YEAR 1-14-1930  | 6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.                     | 7. IF UNDER 1 YR. MONTHS DAYS  | 8. IF UNDER 24 HRS. HOURS MIN.  | 2c. DATE PRONOUNCED DEAD 1 16 19 83  |  | 2d. HOUR 4:20 PM   |  |  |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.   |              | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.                                     |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH Baltimore  |              | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 523 S. Oldham Street |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABOR           |  | 12b. KIND OF BUSINESS OR INDUSTRY Topps Co.  |  |  |  |  |
| 13a. STATE MD.   |              | 13b. COUNTY BALT. MORE  |   | 13c. CITY OR TOWN BALT. MORE   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS 523 S. Oldham St. 21224                      |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST Wm. Thomas Hickman  |              |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST JEWEL FISHER  |  |   |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO  |              |   | 16b. SOCIAL SECURITY NO. 726-36-5016                        |  | 17. INFORMANT ADDRESS CAROLYN RUSSELL PARKSLEY VA.                            |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |              |   |   |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |              |   |   |  |   |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |              |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |   |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |              |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR P.M. 19     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |              |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |              |   |   |  |   |  |  |  |  |  |  |
| ACTUAL SIGNATURE Thomas D. Smith   |              |   | TITLE (SPECIFY) M. Deputy Chief                             |  |   | MEDICAL EXAMINER   |  |  | DATE SIGNED 1/17/83  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.  |              |   | ADDRESS 111 Penn St. Balto., MD.                            |  |   |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |              |   | 23b. DATE 1-22-83   |  | 23c. NAME OF CEMETERY OR CREMATORY PARKSLEY Cem                               |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE Parksley-Accomack-VA. |  |  |  |
| 24. FUNERAL DIRECTOR NAME Thomas J. Skarda   |              |   | ADDRESS 2829 HUDSON ST                                      |  |   | 25a. DATE REC'D. BY REGISTRAR FEB 7 1983   |  |  | 25b. REGISTRAR'S SIGNATURE John J. Canine  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8301019

REG. NO.

|   |  |  |   |   |   |   |  |  |
|---|--|--|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Edward Hicks</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-27-83</b> |   | 2b. HOUR<br>MIN.<br><b>10<sup>05</sup></b> M.                             |   |  |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>Black</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5-9-13</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)          |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Hicks</b>  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>N/A</b>   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>216-03-7939</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Virginia Hicks 5608 Fern Park Avenue</b>   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4360</b> IMMEDIATE CAUSE (a) <b>Aspiration &amp; vomiting</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>5/P CVA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-11</b> , 19 <b>83</b> , to <b>1-27</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>1-27</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                    |  |  |   |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Brian Mulkerin, MD</b>   |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   |   | 22c. DATE SIGNED<br><b>1-27-83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Brian Mulkerin</b>  |  |  |   | 22e. ADDRESS<br><b>Sinai Hospital, Baltimore, Md</b>  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>1/31/83</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn Md.</b>                               |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H Inc, 1101 E. North Avenue</b>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>JAN 28 1983 John J. Carver</b>   |   |   |  |  |

BP



MANITOWOC

JOHN S. 1893  
John S. 1893

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH   |  | MONTH DAY YEAR   |  | 7b. HOUR  |  |
| DECEASED NAME (TYPE OR PRINT)   |  | 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  |
| DR. Benjamin Highstein  |  | MALE  |  | WHITE  |  | SEPT. 17, 1910  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| MARYLAND  |  | USA   |  |  |  | Baltimore city MD.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Baltimore city  |  | N. CHARLES GEN. HOSPITAL  |  | PHYSICIAN  |  | MEDICINE  |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  |
| MARYLAND  |  | BALTO.  |  | BALTIMORE  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  |
| MORRIS HIGHSTEIN  |  | DORA GREEN  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 216-44-1136   |  |
| 17. INFORMANT   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| MRS. HILDA HIGHSTEIN  |  | ACUTE Pulmonary Edema And Cardogenic Shock  |  |  |  |   |  |
| 3203 OLD POST DR., APT. 6 #21208  |  | ACUTE myocardial infarction   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  | 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  |
|   |  |   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|   |  | P.M. 19   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
|   |  |   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/19/83 to 1/22/83, that (I) (we) last saw the deceased alive on 1/22/83, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  | 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED  |  |
|   |  | Marcos B. Galicia Jr. MD  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 1/22/83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  |
| MARCOS B. GALICIA, Jr. MD   |  | North Charles Gen. Hospital   |  | BURIAL   |  | JAN. 24, 1983   |  |
|   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |
|   |  |   |  | BETH EL MEM. PARK  |  | RANDALLSTOWN BALTO. MD.   |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |
| SOL LEVINSON & BROS., INC.  |  | JAN 26 1983   |  | [Signature]  |  |   |  |
| NAME ADDRESS  |  | 6500 REVERSON RD. BALTO., MD 21215  |  |  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be destroyed for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 0 2 1

REG. NO.

|   |  |  |  |   |   |  |                                     |   |   |
|---|--|--|--|---|---|--|-------------------------------------|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Robert Clair Hildebrand  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 13, 1983                |   |   | 2b. HOUR<br>2:30 a.m.  |                                     |   |   |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>August 15, 1909   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73  |                                     | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U S A  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |                                     |   |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retail   |                                     | 12b. KIND OF BUSINESS OR INDUSTRY<br>Retired  |   |
| 13a. STATE<br>Maryland  |  |  | 13b. CITY OR TOWN<br>Catonsville                                       |   | 13c. STREET ADDRESS<br>1504 Tredegar Ave. 21228                               |  |                                     |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Hildebrand  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Adelaide Haesloop     |   |   |  |                                     |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>yes   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW 2        |   | 17. INFORMANT<br>1504 Tredegar Road 21228<br>Mrs. Catharine Hildebrand        |  |                                     |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>1629 IMMEDIATE CAUSE (a) Carcinoma of the lung with bone metastasis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |  |  |   |   |  |                                     |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                     | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                                     |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |                                     |   |   |
| 22a. I certify that (I, this hospital) attended the deceased from January 9, 1983, to January 13, 1983, that (I, we) lost<br>saw the deceased alive on January 13, 1983, and that in (my, our) opinion death occurred on the date and hour and from the causes stated<br>above, (I, we) (did, did not) view the body after death.   |  |  |  |   |   |  |                                     |   |   |
| 22b. SIGNATURE<br>Jim Jer Hwu   |  |  | DEGREE<br>M.D.   |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                     | 22c. DATE SIGNED<br>1/13/83   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jim Jer Hwu, M.D.  |  |  | 22e. ADDRESS<br>c/o Maryland General Hospital                          |   |   |  |                                     |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  | 23b. DATE<br>1/15/83   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Mausoleum                        |  | 23d. LOCATION<br>Baltimore Maryland |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>16 30 Edmondson Ave., Catonsville, Md.<br>Witzke Catonsville Funeral Home, P.A. 21228   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 17 1983                           |   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                                     |  |                                     |   |   |

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on Item 18, check only injury, or other traumatic event, the medical examiner must be notified.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 0 2 2

REG. NO.

|  |  |   |  |  |  |   |   |  |   |  |
|--|--|---|--|--|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Edward F. Hill</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 / 30 / 83</b>              |  |  | 2b. HOUR<br><b>4:16 PM</b>  |   |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 / 1 / 03</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b>  |   | 7. UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>   |   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                           |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Selton Hill Manor</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Farmer / Laborer</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>501 W. Franklin Street</b>          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles T. Hill</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lucy V. Scott</b>  |  |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>218-16-0882</b>                         |  | 17. INFORMANT<br>ADDRESS<br><b>Alan A. Anderson Jr (nephew) 5809 Edison Lane Rockville Md.</b> |   |   |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY:<br><b>1519</b> IMMEDIATE CAUSE (a) <b>Cardio-respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Carcinomatosis (stomach + liver)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hrs.</b> |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.<br><b>Rt. sided stroke w/ (2) hemiparesis</b>  |  |   |  |  |  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                 |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/24</b> , 19 <b>83</b> , to <b>1/30</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1/30</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (I did) (did not) view the body after death.   |  |   |  |  |  |   |   |  |   |  |
| 23a. SIGNATURE<br><b>Danni Punzalan MD</b>   |  |   |  |  | DEGREE   |   |   | 23c. DATE SIGNED   |   |  |
| 23b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. PUNZALAN MD</b>   |  |   |  |  | 23d. ADDRESS<br><b>5214 Harford rd. Balto md. 21214</b>  |   |   |  |   |  |
| 24a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>   |  |   | 24b. DATE<br><b>2-4-83</b>   |  | 24c. NAME OF CEMETERY OR CREMATORY<br><b>Mutual Memorial Cem.</b>                              |   |   | 24d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Sandy Spring, Montgomery Md.</b>  |   |  |
| 24e. FUNERAL DIRECTOR<br><b>George R. Snowden</b>  |  |   |  |  | 24f. ADDRESS<br><b>246 N. Washington Rockville, Md.</b>  |   | 25. DATE REC'D BY REGISTRAR<br><b>FEB 4 1983</b>  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advised.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 3 0 1 0 2 3<br>REG. NO.   |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Harvey C HILL</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 11, 1983</b>  |  |  |  | 2b. HOUR<br><b>6:10a M</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 1 17</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13a. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>   |  | 13b. STREET ADDRESS<br><b>1217 Argyle Avenue</b> <b>21217</b>                                      |  |  |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Sam Hill</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Smith</b>   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>224-12-0624</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Rev. Rose M. Hill 1217 Argyle Ave.</b>                              |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Aspiration Pneumonia</b><br><b>4100</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Multiple Cerebrovascular accidents</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>11/82 to 1/11/83</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (x) (this hospital) attended the deceased from <b>November 15, 1982</b> , to <b>January 11, 1983</b> that (we) lost above (x) (we) (did) view the body after death.   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Tommy T. Hsu MD</b>  |  |   |  | DEGREE<br><b>MD</b>   |  |  |  | 22c. DATE SIGNED<br><b>1/11/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>TOMMY T. HSU MD</b>   |  |   |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/17/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Veteran Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crownsville MD</b>                                |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 12 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>  |  |  |  |

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Psychological Information

Article 1, Revolutionary Principles

Assimilation Process

Psychological Generalization

Psychological City

January 11, 1963

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Psychological Generalization

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Items 19a &amp; b G576 2/23/83 dad

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8301024

REG. NO.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Vetta H. HILMAN  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>01 20 83   |  | 2b. HOUR<br>4:55 A.M.  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>03 12 09                                       |  |
| 6. AGE [IN YEARS LAST BIRTHDAY]<br>73 YRS  |  | 7. BIRTHPLACE [STATE OR FOREIGN COUNTRY]<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3711 GLEN AVE.                           |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE        |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME   |  |   |  |  |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>BALTIMORE   |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>3711 GLEN AVE.   |  | #21215   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>SAMUEL RUBIN   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>IDA SLAMOWITZ  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-10-8694  |  | 17. INFORMANT<br>MR. LOUIS HILMAN<br>3711 GLEN AVE. BALTO., MD 21215                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ? Septic Shock<br>4599<br>DUE TO, OR AS A CONSEQUENCE OF (b) infected bypass graft<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Diabetes Mellitus & Arteriosclerotic Cardiovascular Disease |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>12/23/82   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Ischemia of right lower extremity   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  |  |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/17, 1982, to 1/20, 1983, that (I) (we) lost saw the deceased alive on 1/20, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |
| 22b. SIGNATURE<br>Paul Schwartz M.D.   |  | DEGREE<br>M.D.  |  | 22c. DATE SIGNED<br>1/20/83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PAUL Schwartz M.D.  |  | 22e. ADDRESS<br>Sinn Hosp. Belvedere & Greenspring 21215  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>JAN. 21, 1983  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>CHIZUK AMUNO                                   |  |
| 23d. LOCATION<br>CITY OR TOWN<br>BALTIMORE   |  | COUNTY<br>MARYLAND  |  | STATE  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 26 1983  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Conner   |  |

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SOL LEVINSON & Bros. Inc.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers (Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/82  
(VRA 15, 4)FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 0 2 5

REG. NO.

|   |  |  |  |   |                             |  |   |   |  |                               |  |
|---|--|--|--|---|-----------------------------|--|---|---|--|-------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Amanda Bennett Hilton  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 3, 1983                         |   | 2b. HOUR<br>9:26 PM         |  |   |   |  |                               |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9/25, 1885  |                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br>97 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  | IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S. Carolina  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                     |   |   |  |                               |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |  |   |                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired                    |   | 12b. KIND OF BUSINESS OR INDUSTRY         |  |                               |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Balto. |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>1232 N. Ellwood Ave (13)  |                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Amos Robinson Bennitt   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Unity Robinson                |   |                             |  |   |   |  |                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>no  |  |  | 16b. SOCIAL SECURITY NO.<br>213-54-0052  |   |                             | 17. INFORMANT<br>ADDRESS<br>Rev. David Hilton 1232 N. Ellwood Ave                              |   |   |  |                               |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ventricular Tachycardia</u><br>4280 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Pulmonary Edema</u><br>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last<br>(c) <u>Congestive Heart Failure</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>30 sec.<br>1 day<br>15 days |  |  |  |   |                             |  |   |   |  |                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Fracture right femoral neck, High Blood Pressure, Mitral stenosis</u>   |  |  |  |   |                             |  |   |   |  |                               |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                               |   |                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>7:20 P.M. 12 19 1982        |   |                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br>FELL AT HOME |   |   |  |                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>HOME |   |                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>1232 N. Ellwood Ave. City.                |   |   |  |                               |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>December 19, 1982</u> , to <u>January 3, 1983</u> , that (X) (we) last saw the deceased alive on <u>January 3, 1983</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (did not) view the body after death.  |  |  |  |   |                             |  |   |   |  |                               |  |
| 22b. SIGNATURE<br>Janice Rutkowski, M.D.  |  |  | DEGREE<br>M.D.   |   |                             | 22c. DATE SIGNED<br>January 3, 1983  |   |   | 22d. ADDRESS<br>c/o Maryland General Hospital  |                               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  | 23b. DATE<br>1/7/83  |   |                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem   |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Westport, Maryland   |                               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Chas A. Rice FSPA 1300 Eutaw Pl   |  |  |  |   |                             | 25a. DATE REC'D. BY REGISTRAR<br>JAN 11 1983   |   |   | 25b. REGISTRAR'S SIGNATURE<br>John J. Gries  |                               |  |

MEDICAL CERTIFICATION

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James A. Rice (1900-1974)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be retained by the funeral director. It should be detached for use as the burial-transit permit. Then please remove carbon copies, sign, and date. It should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |                           | 8 3 0 1 0 2 6  |  |
|---|--|--|--|---|--|---|--|--|---------------------------|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   | REG. NO.   |   |  |  |                           |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>PRONETTA HILTON</b>   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01/28/83</b> |   |  |  | 2b. HOUR<br><b>6:35pm</b> |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 12 20</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS.</b>  |                           | IF UNDER 24 HRS<br>HOURS MIN.<br><b>YRS.</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |  |                           |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |                           | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>21213 2005 E. Preston St.</b>                              |                           |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Hilton</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Odessa Langley</b>  |  |   |  |  |                           |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>240-26-9926</b>  |  | 17. INFORMANT ADDRESS<br><b>Zara Howard 2005 E. Preston St.</b>   |  |  |                           |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>5728 IMMEDIATE CAUSE (a) respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hour</b><br><b>12 hours</b> |  |  |  |   |  |   |  |  |                           |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b)<br><b>liver failure</b>  |  |  |  |   |  |   |  |  |                           |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  |  |                           |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                           |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>December 28, 1982</b> to <b>January 28, 1983</b> , that (II) (we) last saw the deceased alive on <b>January 28, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |                           |  |  |
| 22b. SIGNATURE<br><b>ESSIE WOODS</b>  |  |  |  |   |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/28/83</b>   |                           |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ESSIE WOODS</b>   |  |  |  |   |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital 600 N. Wolfe St Baltimore, MD 21205</b>   |  |  |                           |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  |  | 23b. DATE<br><b>2/3/83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Anne Arundel Co. MD</b>             |                           |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E. North Ave.</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 2 1983</b>  |  |  |                           |  |  |
|   |  |  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Lohr</b>   |  |  |                           |  |  |

BP



NYF 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/B1  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 01027

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |                         |  |   |  |  |  |                                   |   |  |  |  |  |  |
|--|--|-------------------------|--|---|--|--|--|-----------------------------------|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Johnnie Hines</b>   |  |                         | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>1/29/83</b>   |   |  | 2b. HOUR<br><b>8:56 AM</b>   |  |                                   |   |  |  |  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>BLACK</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>9 20 14</b> |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS <b>3</b> MONTHS <b>10</b> DAYS  |  | 7. IF UNDER 24 HRS.<br>HOURS MIN. |   |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>HALIFAX Co. N.C.</b>   |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BON SECOURS Hospital</b> |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>none</b>  |  |                                   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MARYLAND</b> |  |                         | 13b. COUNTY <b>Baltimore</b>   |   |  | 13c. CITY OR TOWN <b>Baltimore</b>   |  |                                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS<br><b>1823 EDMONDSON AVE</b>               |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>JOSEPH H HINES</b>   |  |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>MADONA SCOTT</b>  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>   |  |                                   | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT<br>ADDRESS <b>Joan Ra Wallace 1823 Edmondson</b> |  |  |

|  |  |  |  |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1629</b> IMMEDIATE CAUSE (a) <b>CARDIO VASCULAR COLLAPSE</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>7:30 to 8:56 AM</b> |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CANCER of the LUNG</b>  |  | ≈ 1 year.  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/30/83</b> , 19 <b>83</b> , to <b>1/30/83</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1/30/83</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Eugene Lundy</b>   |  | DEGREE <b>M.D.</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/30/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>EUGENE LUNDY</b>  |  | 22e. ADDRESS<br><b>BON SECOURS Hospital Baltimore, Maryland 21223</b>  |  |  |  |  |  |

|  |  |                            |  |  |  |   |  |
|--|--|----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>             |  | 23b. DATE<br><b>2/3/83</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT AUBURN</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mr. Lundy 635 N. 5th St</b> |  |                            |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 2 1983</b>     |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connelley</b>            |  |



LEB 5 1983

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 0 2 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |                                      |  |  |                                    |  |  |  |
|---|---|--------------------------------------|--|--|------------------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   |                                      | 2a. DATE OF DEATH  |  |                                    | 2b. HOUR   |  |  |
| REGINA M. HITT  |   |                                      | January 2, 1983  |  |                                    | 10:50p   |  |  |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH                     | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |                                    | 7. IF UNDER 1 YEAR   |  |  |
| F   | WHITE   | AUG. 18, 1942                        | 40 YRS.  |  |                                    | MONTHS DAYS HOURS MIN.   |  |  |
| 8. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   | 9b. CITIZEN OF WHAT COUNTRY?  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |  |                                    |  |  |  |
| MD.   | U.S.A.  | BALTIMORE CITY MD.                   |  |  |                                    |  |  |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)       |  |                                    | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| BALTIMORE   | THE JOHNS HOPKINS HOSPITAL  |                                      | Maryland Cup   |  |                                    |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |                                      | 13b. INSIDE CITY LIMITS?   |  |                                    | 13c. STREET ADDRESS  |  |  |
| MD.   |   |                                      | YES <input type="checkbox"/> NO <input type="checkbox"/>               |  |                                    | 730 S. ROBINSON ST. 21224  |  |  |
| 14. FATHER'S NAME   |   |                                      | 15. MOTHER'S MAIDEN NAME   |  |                                    |  |  |  |
| WILLIAM SCHULTHEIS  |   |                                      | ANNA STEWART   |  |                                    |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   |                                      | 16b. SOCIAL SECURITY NO.   |  |                                    | 17. INFORMANT ADDRESS  |  |  |
| NO  |   |                                      | 214-40-7797  |  |                                    | JIMMY L. HITT SAME 21224   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIAC ARREST<br>4240<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) PROLONGED HYPOTENSION<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) MITRAL valve THROMBOSIS<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>15 min<br>8 hrs |   |                                      |  |  |                                    |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>METABOLIC ACIDOSIS   |   |                                      |  |  |                                    |  |  |  |
| 19a. DATE OF OPERATION  |   |                                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |                                    | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| 1/2/82  |   |                                      | THROMBOSIS MITRAL VALVE  |  |                                    | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   |                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   |                                      | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/2/82, 19, to 1/2/83, 19, that (I) (we) lost saw the deceased alive on 1/2, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)   |   |                                      | 22b. SIGNATURE<br>E. Ruas MD   |  |                                    | 22c. DATE SIGNED<br>1/2/83   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |   |                                      | 22e. ADDRESS   |  |                                    |  |  |  |
| RUAS, E.  |   |                                      | JOHNS HOPKINS HOSPITAL   |  |                                    |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)  |   |                                      | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |
| BURIAL  |   |                                      | 1-5-83   |  | SAC HEART OF JESUS                 |  | BALTO. CO. MD.                             |  |
| 24. FUNERAL DIRECTOR<br>NAME  |   |                                      | 25. DATE REC'D. BY REGISTRAR   |  |                                    | 25b. REGISTRAR'S SIGNATURE   |  |  |
| THOMAS J. SKARDA  |   |                                      | JAN 4 1983   |  |                                    | John J. Casella  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page always be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 01029

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>John E. Hittle</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-9-83</b>  |   | 2b. HOUR<br><b>8:45 AM</b>   |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Caucasian</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3-13-05</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77 77</b> YRS.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto</b> city MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE) (WORKING LIFE)<br><b>Mechanic</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>MTA</b>    |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>BALTO</b>   | 13c. CITY OR TOWN<br><b>BALTO</b>                                 | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>3549 CHESTERFIELD AV</b> |
| 14. FATHER'S NAME<br><b>John Phillip Hittle</b>   |  | 15. MOTHER'S MAIDEN NAME<br><b>Annie Grier</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214-03-7809</b>  |   | 17. INFORMANT<br><b>Lillian Hittle</b> ADDRESS<br><b>21213 3549 Chesterfield Ave</b>                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4439</b><br>IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PLM EMBOLUS, SEPTIC SHOCK</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>PERIPHERAL VASCULAR DISEASE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>DIABETES MELLITUS, COPD</b>  |  |   |   |  |  |
| 19a. DATE OF OPERATION<br><b>12/29/82</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>occluding VASC DIS</b>   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)       |   |  |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>83</b>   |  |
| 22a. I certify that (I) (his hospital) attended the deceased from <b>8/12/27</b> 19 <b>82</b> to <b>1/9</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1/9</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.  |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Dean Kane MD</b>   |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>1/9/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DEAN KANE MD</b>  |  | 22e. ADDRESS<br><b>SINAI HOSPITAL OF BALTO</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1-12-83</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith Cem.</b>                                     |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>  |  | 24. FURNERAL DIRECTOR<br><b>Schmunek Funeral Home, Inc.</b>   |   |  |  |
| 25a. REGISTRATION<br><b>JAN 11 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Joan J. Connel</b>   |   |  |  |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |              |   |  |   |   |   |  |   |                       | REG. NO. 01030   |  |
|---|--------------|---|--|---|---|---|--|---|-----------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) Frank Hobson  |              |   |  |   |   |   | 2a. DATE KNOWN OF DEATH<br>XX MONTH DAY YEAR 1 1 19 83 |   | 2b. HOUR<br>a.m. 6:18 |  |  |
| 3. SEX<br>M   | 4. RACE<br>B | 5. DATE OF BIRTH<br>MONTH DAY YEAR 12-16-92   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY 90 YRS. | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   | IF UNDER 24 HRS.  | 7c. DATE PRONOUNCED DEAD<br>1 1 19 83   | 7d. HOUR<br>a.m. 6:18                                  |   |                       |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA   |              | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                     |  |   |                       |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |              | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1100 blk. N. Carey Street |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY                      |   |                       |  |  |
| 13a. STATE<br>Md  |              | 13b. COUNTY<br>BALTO  |  | 13c. CITY OR TOWN<br>BALTO  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1039 N. Carey St 21217                                       |                       |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |              |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |   |   |  |   |                       |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) NO  |              | 16b. SOCIAL SECURITY NO.<br>?   |  | 17. INFORMANT<br>H. Ha Cadwell  |   | ADDRESS<br>5301 Wesley Ave  |  |   |                       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>8950 IMMEDIATE CAUSE (b) Smoke & Soot Inhalation<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. |              |   |  |   |   |   |  |   |                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |              |   |  |   |   |   |  |   |                       |  |  |
| 19a. DATE OF OPERATION  |              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                       |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR 5:41 PM 1 1 19 83   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br>subject in housefire   |   |   |  |   |                       |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |              | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>Home   |  | 21f. LOCATION<br>1039 N. Carey St., 3rd fl., Balto., Md.  |   |   |  |   |                       |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |              |   |  |   |   |   |  |   |                       | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |
| ACTUAL SIGNATURE<br>Dennis F. Smyth, M.D.   |              | TITLE (SPECIFY)<br>Assistant MEDICAL EXAMINER   |  |   |   |   |  | DATE SIGNED<br>1-1-83   |                       |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) Dennis F. Smyth, M.D.  |              | ADDRESS<br>111 Penn Street  |  |   |   |   |  |   |                       |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) Burial   |              | 23b. DATE<br>1/6/83   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem  |   |   |  | 23d. LOCATION<br>CITY OR TOWN BALTO COUNTY MD STATE                                 |                       |  |  |
| 24. FUNERAL DIRECTOR<br>Bridget J. H.   |              | ADDRESS<br>1348 N. Calhoun St.  |  |   |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 5 1983   |                       | 25b. REGISTRAR'S SIGNATURE<br>John J. Connel   |  |

MEDICAL CERTIFICATION

RECEIVED

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RECEIVED BY THE DIRECTOR OF THE BUREAU OF INVESTIGATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/B1  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 0 3 1

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Anna M Hooges   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>01 14 83                               |  | 2b. HOUR<br>3:00 A.M.   |
| 3. SEX<br>FEMALE  | 4. RACE<br>BLACK   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 8 10  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |
| 7a. BIRTHPLACE<br>(COUNTRY)<br>NC   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SOUTH BALTIMORE Gen Hsp |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br>MO  |  |   | 13b. COUNTY<br>BALTIMORE  | 13c. CITY OR TOWN<br>BALTIMORE   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Kane  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Betty McCloud                |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>212-26-1013   |   | 17. INFORMANT<br>ADDRESS<br>CORA BULLOCK 700 Roundview Rd                            |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>2030 IMMEDIATE CAUSE (a) CARDIAC ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) MULTIPLE MYELOMA<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 16 |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 11 Jan 1983 to 14 Jan 1983, that (I) (we) last saw the deceased alive on 13 Jan 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (and) not view the body after death.   |  |   |   |  |   |
| 22b. SIGNATURE<br>J.B. CORN   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br>14 Jan 83  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J.B. CORN  |  | 22e. ADDRESS<br>3001 S. HANOVER, BALTIMORE  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>1/18/83  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Pk.                               |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arbutus, Md.  |  | 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H 1101 E. North Ave  |   |  |   |
| 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE<br>JAN 17 1983 John J. Carver  |   |  |   |

MEDICAL CERTIFICATION

Page 5 of 10

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 0 3 2

FOR  
1- STATE  
REGISTRAR

REG. NO.

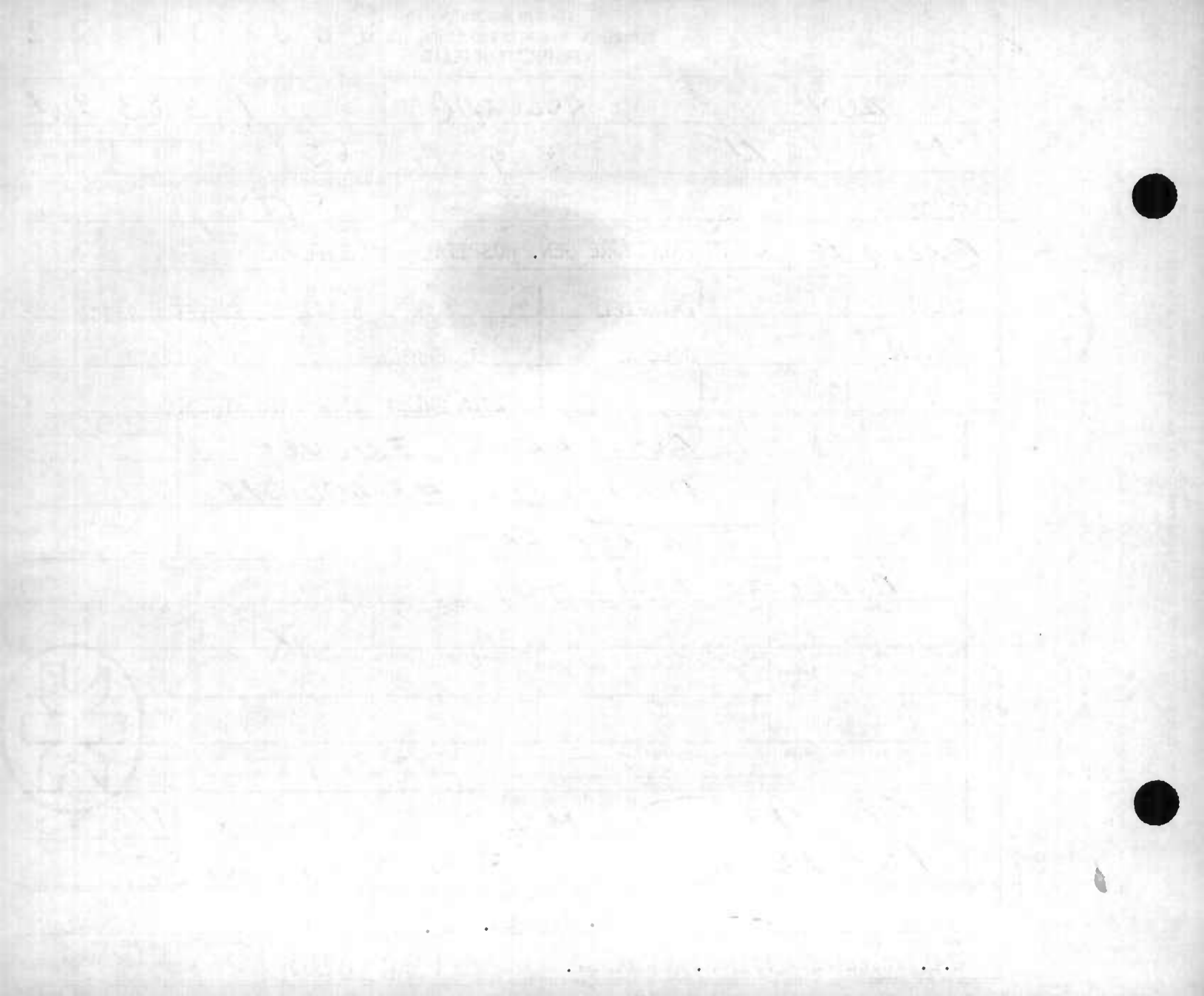
|   |  |   |   |   |                              |  |  |
|---|--|---|---|---|------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ROY HOLLAND</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1 5 83</b> |   | 2b. HOUR<br><b>2:10 P.M.</b> |  |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>N</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>8 9 17</b>  |                              | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br><b>65</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN WHICH FACILITY THE DECEASED RESIDED)<br><b>SOUTH BALTIMORE GEN. HOSPITAL</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORKER, MOST OF WORKING LIFE)<br><b>MAINTENANCE</b>  |                              | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>   |  |   |   | 13b. CITY OR TOWN<br><b>FAIRFIELD</b>   |                              | 13c. STREET ADDRESS<br><b>3324 TATE STREET 21226</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>STEVE HOLLAND</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>JOSEPHINE HOLLAND</b>  |                              |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS<br><b>SYLVIA QUEEN 3324 TATE STREET</b>   |                              |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4151 IMMEDIATE CAUSE (a) RESPIRATORY FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PULMONARY EMBOLISM</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>OR ASPIRATION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |   |   |                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>DIABETES MELLITUS</b>  |  |   |   |   |                              |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                              |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |                              |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |                              |  |  |
| 22b. SIGNATURE<br><b>M. McCarty</b>   |  | DEGREE<br><b>M.D.</b>   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |                              | 22c. DATE SIGNED<br><b>1/5/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MCCARTHY</b>  |  | 22e. ADDRESS<br><b>30015 Hanover ST.</b>  |   |   |                              |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>  |  | 23b. DATE<br><b>1-8-83</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. ZION CH. CEM.</b>  |                              | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>MAGATHY MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>E.L. PHILLIPS</b>   |  |   |   | 1721 N. MONROE ST.  |                              | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 10 1983</b>  |  |
|   |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>   |                              |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, 3, and 4 should be filed and the final copy of the death certificate should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner must be notified.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the funeral director's office within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 3 0 1 0 3 3  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | CERTIFICATE OF DEATH   |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |  |  |  | 2a DATE OF DEATH   |  |  |  |
| FIRST MIDDLE LAST<br><b>GEORGE D. HOLLEY</b>   |  |  |  | MONTH DAY YEAR<br><b>JANUARY 26, 1983</b>  |  |  |  |
| 3 SEX<br><b>MALE</b>   |  |  |  | 2b HOUR<br><b>7 P.M.</b>   |  |  |  |
| 4 RACE<br><b>NEGRO</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JAN 1 1900</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>      |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2104 BRYANT AVENUE</b> |  | 12a. USUAL OCCUPATION<br>(SPECIFY EMPLOYER OR MOST OF WORKING LIFE)<br><b>LABOR EXEC.</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  |  |  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ROSE</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>HOLLEY</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>214-14-5604</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>RUBY C. HOLLEY/2104 BRYANT AVE 21217</b>  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>META STATIC CARCINOMA OF PROSTATE</b><br><b>1850</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>9 YRS.</b>  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) <del>subscribed</del> attended the deceased from <b>SEPT. 24, 1970</b> to <b>JAN. 26, 1983</b> , that (I) <del>lost</del> saw the deceased alive on <b>JAN. 15, 1983</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>subscribed</del> (did not) view the body after death.        |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Carlton L. Sexton -</b>   |  |  |  | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/27/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Carlton L. Sexton, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>Baltimore Life Building<br/>901 N. Howard, Balto., MD 21201</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)<br><b>ENTOMBMENT</b>  |  | 23b. DATE<br><b>01/31/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARBUTUS MEMORIAL</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE BALTO MD</b>  |  |
| 24 FUNERAL DIRECTOR<br><b>MARSHALL W JONES, JR/4101</b>  |  |  |  | EDMONDSON AVE  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 31 1983</b>  |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. C. Carver</b>  |  |  |  |



UNCLASSIFIED

DATE

JAN 12

82

Carlton L. Sexton, M.D.

601 W. Howard, Balto., Md. 21201  
Baltimore Life Building

1/12/82

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |   | REG. NO.   |   |
|---|--|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Mary C. Holloway</i>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>January 8, 1983</i>               |   | 2b. HOUR<br>M<br><i>M</i>  |   |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>White</i>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>February 18, 1895</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>87</i> YRS.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Virginia</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                               |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>5512 Sefton Ave.</i> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Homemaker</i> |   |
| 13a. STATE<br><i>Maryland</i>   |  | 13b. COUNTY<br><i>---</i>  |   | 13c. CITY OR TOWN<br><i>Baltimore</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>George A. Clary</i>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Georgia Ann Unknown</i> |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>---</i>  |   | 17. INFORMANT<br><i>Baltimore, Md 21214</i><br><i>Elizabeth M. Moon 5512 Sefton Ave.</i>  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i><br><i>4140</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Anteroseptal heart disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>---</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>minutes</i><br><i>years</i> |  |  |   |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.   |  |  |   |   |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>---</i> P.M. <i>19</i>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><i>---</i> <i>---</i> <i>---</i> <i>---</i>  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 8, 1983</i> to <i>present</i> , that (I) (we) last saw the deceased alive on <i>Jan 8, 1983</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |   |
| 22b. SIGNATURE<br><i>Richard M. Hirata</i>  |  |  |   | DEGREE<br><i>MD</i>   |  | 22c. DATE SIGNED<br><i>1-8-83</i>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Dr. Richard M. Hirata</i>   |  |  |   | 22e. ADDRESS<br><i>11703 Fallwood Terrace</i>   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>1-11-83</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Forest Lawn Cemetery</i>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Richmond --- Virginia</i>                      |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Loring Byers Funeral Directors, Inc</i><br><i>8728 Liberty Rd. Randallstown, Md. 21133</i>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 11 1983</i>   |  |   |
|   |  |  |   | 25. REGISTRAR'S SIGNATURE<br><i>John J. Carver</i>  |  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 3 0 1 0 3 5   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>WALTER BERNARD HOOK SR.  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>1 12 83                                   |  |  |  |
| 3. SEX<br>M  |  |  |  | 2b. HOUR<br>11:45 P M   |  |  |  |
| 4. RACE<br>W   |  | 5. DATE OF BIRTH<br>7-12-1914  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS                                     |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                     |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VAMC Baltimore, Maryland |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MECHANIC     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>CITY                                |  |
| 13a. STATE<br>MD.  |  | 13b. COUNTY<br>BALTO.  |  | 13c. CITY OR TOWN<br>BALTO.   |  | 13d. INSIDE CITY LIMITS?<br>YES X NO                                     |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>TOWNSEND HOOK   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>LEONA SMITH  |  | 13e. STREET ADDRESS<br>2837 FLEETWOOD AVE.                                    |  | 21214  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>YES   |  | 16b. SOCIAL SECURITY NO.<br>W.W. II 212 10 7448  |  | 17. INFORMANT ADDRESS<br>Mrs. Annie M. Hook - 2837 Fleetwood Ave.             |  | 21214  |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>1541 IMMEDIATE CAUSE (a) rectal carcinoma metastatic<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES NO   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES NO |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>WHILE AT WORK NOT WHILE AT WORK  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from OCTOBER 8, 1982, to JANUARY 12, 1983, that (I) (we) lost the deceased alive on JANUARY 12, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>[Signature]  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN MEDICAL DIRECTOR STAFF PHYSICIAN X              |  | 22c. DATE SIGNED<br>1/13/83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS<br>3900 Loch Raven Blvd. Balto., Md. 21218                       |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>1-17-83   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GARDENS OF FAITH CEM.                   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTO. MD.                    |  |
| 24. FUNERAL DIRECTOR<br>[Signature] - 7527 Hanford Rd.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 17 1983                                  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                                |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  | REG. NO. 8301036  |   |
|---|--|--|--|--|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) <b>KATHERINE SUSAN Hooper</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>1-17-83</b>  |  | 2b. HOUR <b>1245 PM</b>   |   |
| 3. SEX <b>FEMALE</b>  |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>8 5 87</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>35 Md</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD</b>   |   |
| 10. CITY OR TOWN OF DEATH <b>43 Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Balto. Genl Hosp</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housekeeper</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| 13a. STATE <b>35 Md</b>   |  |  |  | 13b. COUNTY <b>BALTO</b>   |  | 13c. CITY OR TOWN <b>BALTO.</b>   |   |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  | 13e. STREET ADDRESS <b>3568 HORTON Ave. 21225</b>  |  |   |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>James Henry ELLIOTT</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alice GATTON</b>   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>1 NO</b>   |  |  |  | 16b. SOCIAL SECURITY NO. <b>212-28-0438</b>  |  | 17. INFORMANT ADDRESS <b>R. Pisco 3001 S. HANOVER St. BALTO.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4280 Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>congestive Heart failure +</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>aspiration Pneumonia</b>   |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b><br><b>2 wks</b><br><b>72 hrs</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Progressive Renal Failure</b>   |  |  |  |  |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7 PM 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/14</b> , 19 <b>82</b> , to <b>1/17</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>1/17</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |   |
| 22b. SIGNATURE <b>R. Pisco, M.D.</b> DEGREE   |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED <b>1/17/83</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R Pisco</b>  |  |  |  | 22e. ADDRESS <b>3001 S. HANOVER St. BALTO. Md</b>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>1/20/1983</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Waters Mem. Meth. Cem.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Wallville, Maryland</b>  |   |
| 24. FUNERAL DIRECTOR NAME <b>McCully Funeral Homes</b> ADDRESS <b>Balto., Md., 21225 237 E. Patapsco Ave.,</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 19 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |   |   |  |   |  | REG. NO. 8301037                                  |  |
|---|--|--|--|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST <u>RONALD</u> MIDDLE <u>DIANE</u> LAST <u>HOPKINS, JR.</u>  |  |  |  |  | 2a. DATE OF DEATH MONTH <u>1</u> DAY <u>21</u> YEAR <u>83</u> |   |  | 2b. HOUR <u>12-12</u> PM  |  |   |  |
| 3 SEX<br><u>MALE</u>  |  | 4 RACE<br><u>BLACK</u>   |  | 5. DATE OF BIRTH<br>MONTH <u>12</u> DAY <u>19</u> YEAR <u>82</u>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>1 month 3 days</u>  |  | IF UNDER 1 YEAR<br>MONTHS <u>1</u> DAYS <u>3</u>  |  | IF UNDER 24 HRS<br>HOURS <u>22</u> MIN. <u>32</u> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>MARYLAND</u>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                          |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>      |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>BALTIMORE CITY</u> MD.   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><u>BALTIMORE</u>   |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>BALTIMORE CITY HOSPITAL</u>                      |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                 |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |  |   |   |  |   |  |   |  |
| 13a. STATE<br><u>MARYLAND</u>   |  | 13b. COUNTY<br><u>A.A.</u>   |  | 13c. CITY OR TOWN<br><u>ANNAPOLIS</u>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                      |  | 13e. STREET ADDRESS<br><u>Annapolis, Md. 21401</u><br><u>441 B Boston Heights Circle</u>  |  |   |  |
| 14. FATHER'S NAME<br>FIRST <u>✓</u> MIDDLE <u>✓</u> LAST <u>✓</u>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <u>✓</u> MIDDLE <u>✓</u> LAST <u>✓</u>   |   |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><u>7707</u> IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Severe Bronchopulmonary dysplasia Premethorax</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Severe Hypoxemia. Severe Acidosis. Electolyte imbalance</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Patent Ductus Arteriosus</u> |  |  |  |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH      |  |
| 19a. DATE OF OPERATION<br><u>X</u>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>X</u>           |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <u>19</u>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET <u>BALTIMORE CITY HOSPITAL</u> CITY OR TOWN <u>4940 Eastern Ave.</u> COUNTY <u>MD</u> STATE <u>21224</u>                                 |   |   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |  |   |   |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Fareeda Rizvi</u>  |  |  |  | DEGREE<br><u>M.D.</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   |  | 22c. DATE SIGNED<br><u>1. 21. 83</u>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>FAREEDA RIZVI</u>   |  |  |  | 22e. ADDRESS<br><u>6136 E. Pratt Street Baltimore MD 21224</u>   |   |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><u>BURIAL</u>  |  | 23b. DATE<br><u>1-24-1983</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>CHEWS CHURCH CEMETERY</u>   |   | 23d. LOCATION<br>CITY OR TOWN <u>Owensville</u> COUNTY <u>A.A.</u> STATE <u>Maryland</u>                  |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <u>Annopolis, Md. 21401</u><br><u>WILLIAM REESE &amp; SONS MORTUARY, P.A.</u>  |  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><u>JAN 26 1983</u> <u>John J. [Signature]</u> |  |   |  |   |  |



1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, this certificate should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the funeral director. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |  |  |  |  | 8 3 0 1 0 3 8                                |
|---|--|---|--|---|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR XC 15 741 514  |  |   |  |   |  |  |  |  |  | REG. NO.                                     |
| 1 DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>CHARLES HILDRETH HORRELL</b>   |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JANUARY 13, 1983</b>  |  | 2b. HOUR P<br><b>10:00 M</b>   |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>3 29 29</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>53</b>   |  | 7. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NORTH CAROLINA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE CITY</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE CITY HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>TRACTOR OPERATOR</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BETHLEHEM STEEL</b>  |  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13d. STREET ADDRESS<br><b>1709 EVERGREEN DRIVE 21222</b>   |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Henson Henry HORRELL</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>BEULAH Carter</b>  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(OR UNKNOWN) YES <input checked="" type="checkbox"/>  |  | 16b. SOCIAL SECURITY NO.<br><b>1947-1950</b>  |  | 17. INFORMANT ADDRESS<br><b>CLINICAL RECORDS, VAMC, FORT HOWARD, MD</b>   |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY: <b>PULMONARY EDEMA</b><br><b>4960</b> IMMEDIATE CAUSE (a)<br>DUE TO, OR AS A CONSEQUENCE OF: <b>COR PULMONALE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>SECONDARY POLYCYTHEMIA</b>   |  |   |  |   |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>C.V.J. Vergheese</i>   |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/17/83</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C.V.J. VERGHESE, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>VA MEDICAL CENTER, FORT HOWARD, MD 21052</b>   |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>1/17/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |  |  |  |
| 24. FUNERAL DIRECTOR Duda-Ruck, Inc.<br>NAME ADDRESS<br><b>7922 Wise Avenue Dundalk, MD. 21222</b>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 18 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Connel</i>  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |   |  |  |   |  |   |  | 8   | 3                                | 0                             | 1 | 0                  | 3 | 9 |
|---|--|--|---|--|--|---|--|---|--|---|----------------------------------|-------------------------------|---|--------------------|---|---|
| 1. FOR STATE REGISTRAR  |  |  |   |  |  |   |  |   |  | REG. NO.                                      |                                  |                               |   |                    |   |   |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>NEEDHAM H. HORTON   |  |  |   |  |  |   |  |   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>1 10 83 |                                  |                               |   | 2b HOUR<br>3:00P M |   |   |
| 3 SEX<br>Male   |  |  | 4 RACE<br>Black   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>4 23 1897   |   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS                        |  | IF UNDER 1 YEAR<br>MONTHS DAYS                |                                  | IF UNDER 24 HRS<br>HOURS MIN. |   |                    |   |   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.C.  |  |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.       |  |   |                                  |                               |   |                    |   |   |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE   |  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  |  |   |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  |   | 12b KIND OF BUSINESS OR INDUSTRY |                               |   |                    |   |   |
| 13a STATE<br>MD   |  |  | 13b COUNTY  |  | 13c CITY OR TOWN<br>Baltimore  |   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e STREET ADDRESS<br>1300 E. Lanvale St. 21213  |   |                                  |                               |   |                    |   |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Bryant Horton  |  |  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Polly Ann  |   |  |   |  |   |                                  |                               |   |                    |   |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>219-03-7744   |  | 17 INFORMANT ADDRESS<br>Margerite Hollins 3608 Lucille Avenue  |   |  |   |  |   |                                  |                               |   |                    |   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>PROBABLE ACUTE MYOCARDIAL INFARCTION</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |   |  |  |   |  |   |  |   |                                  |                               |   |                    |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>? GASTRIC ULCER   |  |  |   |  |  |   |  |   |  |   |                                  |                               |   |                    |   |   |
| 19a DATE OF OPERATION<br>NONE   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—   |  |  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |                                  |                               |   |                    |   |   |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br>N/A  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19<br>N/A   |  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>N/A |  |   |  |   |                                  |                               |   |                    |   |   |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/><br>N/A   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>N/A   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>N/A                            |  |   |  |   |                                  |                               |   |                    |   |   |
| 22a I certify that (I) (his hospital) attended the deceased from <u>Jan. 5</u> , 19 <u>83</u> , to <u>Jan. 10</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>Jan 10</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.  |  |  |   |  |  |   |  |   |  |   |                                  |                               |   |                    |   |   |
| 22b SIGNATURE<br>D. Weinreich   |  |  |   |  | DEGREE<br>MD   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br>1/16/83                   |                                  |                               |   |                    |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DEBORAH WEINREICH  |  |  |   |  | 22e ADDRESS<br>UNION MEMORIAL HOSPITAL   |   |  |   |  |   |                                  |                               |   |                    |   |   |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  | 23b. DATE<br>1/14/83  |  | 23c NAME OF CEMETERY OR CREMATORY<br>Md. Nat'l Mem. Pk.  |   |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Laurel MD          |  |   |                                  |                               |   |                    |   |   |
| 24 FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave.  |  |  |   |  |  | 25a DATE REC'D. BY REGISTRAR<br>JAN 12 1983   |  | 25b REGISTRAR'S SIGNATURE<br>John J. Conner                     |  |   |                                  |                               |   |                    |   |   |

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 0 4 0

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MARY Tyler HOWELL   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JAN 13 83                              |   | 2b. HOUR<br>5 <sup>20</sup> PM   |
| 3. SEX<br>Female   | 4. RACE<br>Black  | 5a. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 19, 1892   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>90   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore city MD.                    |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>PROVIDENT HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home   |  |
| 13a. STATE<br>Maryland   |   | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>21216<br>3035 Gwynns Falls Pkwy.  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Basil Tyler  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Monroe  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |   | 16b. SOCIAL SECURITY NO.<br>212-48-4324   | 17. INFORMANT<br>ADDRESS<br>Falls Pkwy.<br>-Mrs. Alice H. Wallace-3035 Gwynns |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>5860 IMMEDIATE CAUSE (a) RESPIRATORY FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br>RENAL FAILURE; HEART FAILURE   |   |   |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-28, 1982, to 1-13, 1983, that (I) (we) last saw the deceased alive on 1-13, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |   |   |  |
| 22b. SIGNATURE<br>Antonio S. Ravidia, M.D.   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br>1-13-83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ANTONIO S. RAVIDIA, M.D.  |   | 22e. ADDRESS<br>PROVIDENT HOSPITAL  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  | 23b. DATE<br>1/18/83  | 23c. NAME OF CEMETERY OR CREMATORY<br>Saint Thomas Cem.   |   | 23d. LOCATION<br>Randallstown CITY OR TOWN BALTO. CO. STATE MD.                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hebert E. Miller - 3035 W. North Ave.  |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 17 1983  |   | 25b. REGISTRAR'S SIGNATURE<br>John J. Connel  |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

Handwritten text at the bottom of the page, possibly a signature or date, including the word "JANUARY".

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 0 4 1

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |  |   |  |   |  |
|---|--|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Nellie NMI O'owell</i>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>1 7 83</i> |   |  | 2b. HOUR<br><i>9:26M</i>  |  |   |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>Caucasian</i>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>2 26 15</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>67</i> YRS.                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>md.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALT CITY</i> MD.                          |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>BALT</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>UNIVERSITY OF MD</i> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>UNEMPLOYED</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><i>BALTIMORE</i>  |  |  |   | 13b. COUNTY<br><i>BALTO</i>   |  | 13c. CITY OR TOWN<br><i>BALTO</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Joseph Gray</i>  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>MARGARET KROH</i>   |  |   |  | 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br><i>BALTIMORE BALTO BALTO</i> |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>No</i> |  | 16b. SOCIAL SECURITY NO.<br><i>212-124380</i>  |   | 17. INFORMANT<br><i>Dolly R. Hall</i>   |  |   |  | ADDRESS<br><i>Box 164A Mechanicsville, Md.</i>  |  |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*1619*

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) *Dehydration*

DUE TO, OR AS A CONSEQUENCE OF

(c) *Cancer of Larynx*APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

## MEDICAL CERTIFICATION

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8/3/83</i> to <i>1/7/83</i> , that (I) (we) last saw the deceased alive on <i>1/7/83</i> above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>R. C. TRAKO</i>  |  |   |  | DEGREE<br><i>MD</i>  |  | 22c. DATE SIGNED<br><i>1/7/83</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>R. C. TRAKO</i>   |  |   |  | 22e. ADDRESS<br><i>22 S. Green St</i>  |  |  |  |

|  |  |                                   |  |   |  |  |  |
|--|--|-----------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>                           |  | 23b. DATE<br><i>Jan. 10, 1983</i> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>St. Joseph's</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Morganza St. Marys Md</i> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>W. Clarke Mattingley Leonardtown, Md.</i> |  |                                   |  | 25a. DATE REC'D BY REGISTRAR<br><i>JAN 13 1983</i>        |  | 25b. REGISTRAR'S SIGNATURE<br><i>John R. Smith</i>                         |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



CHIEFLIN  
BOX 5011



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 0 4 2

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Nellie E. Howell</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 13, 1983</b>                        |  | 2b. HOUR<br>M  |
| 3 SEX<br><b>Female</b>  | 4 RACE<br><b>White</b>   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>August 16, 1913</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b><br>YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                     |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1104 Roland Heights Avenue 21211</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Hand Sewer</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Book Binding</b>   |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>-</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      | 13e. STREET ADDRESS<br><b>3838 Roland Avenue 21211</b>   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Anthony R. Litzinger</b>  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nellie E. Mules</b>                |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218 18 4438</b>   | 17 INFORMANT<br>ADDRESS<br><b>Betty J. Ray 1104 Roland Heights Ave. 21211</b>         |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br><b>4100</b> IMMEDIATE CAUSE (a) <b>Congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>myocardial infarction + mitral insufficiency 710y.s.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Coronary artery disease, arteriosclerotic 710y.s.</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>8 y.s.</b> |  |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/23</b> 19 <b>82</b> to <b>1/13</b> 19 <b>83</b> , that (I) <del>was</del> lost saw the deceased alive on <b>1/3</b> 19 <b>83</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(was)</del> (did) (did not) view the body after death.  |  |  |   |  |  |
| 22b. SIGNATURE<br><b>John E. Greizer</b> M.D.   |  |  |   | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Louis E. Grenzer</b>  |  |  |   | 22e. ADDRESS<br><b>1101 North Calvert St.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/17/83</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park Cemetery Woodlawn</b>          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. Md</b>  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Burgee Funeral Home 3631 Falls Road 21211</b>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>JAN 17 1983</b> <b>John J. Connel</b> |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

January 13, 1953

1100 Island Heights Avenue, 11th and Lower

1100 Island Heights Avenue, 11th and Lower

1100 Island Heights Avenue, 11th and Lower

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1100 Island Heights Avenue, 11th and Lower

1100 Island Heights Avenue, 11th and Lower



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 0 4 3

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |   |   |   |   |   |   |  |
|--|--|---|---|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Mary A. Hudson  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Jan. 29 1983                 |   |   | 2b. HOUR<br>10:55 AM  |   |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug. 3 1908   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>4116 Marx Avenue |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clerk                       |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Balto. Gas & Elec.   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |   |   |   |   |   |   |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY<br>-  |   | 13c. CITY OR TOWN<br>Baltimore  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>4116 Marx Avenue 21206   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Harry Peed   |  |   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Alverta Courtney |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-05-2932  |   | 17. INFORMANT<br>ADDRESS<br>Roberta Winkleman -4222 Seidel Ave.   |   |   |   |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypertensive Corded Vascular Heart disease</u><br>4029<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cerebral Corded Vascular</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Febrile</u>                                  |  |   |   |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>2 years</u>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |   |   |   |   |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19          |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)                  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 1938</u> to <u>1-7-83</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>1-1-83</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |   |   |   |   |  |
| 22b. SIGNATURE<br><u>William L. Fearing M.D.</u>   |  |   |   |   |   | DEGREE<br>M.D.  |   | 22c. DATE SIGNED<br>1-31-83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Wm. L. Fearing  |  |   |   |   |   | 22e. ADDRESS<br>3025 Belair Rd.   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |   | 23b. DATE<br>2/2/83   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore                   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md. |   |  |
| 24. FUNERAL HOME FOR NAME<br>Schimunek Funeral Home, Inc.<br>ADDRESS<br>3331 Brehms Lane, Balto. Md. 21213   |  |   |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 1 1983   |   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP



1000



UNCLASSIFIED

DATE 10/1/00

NOTICE

03101

1000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL FILES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

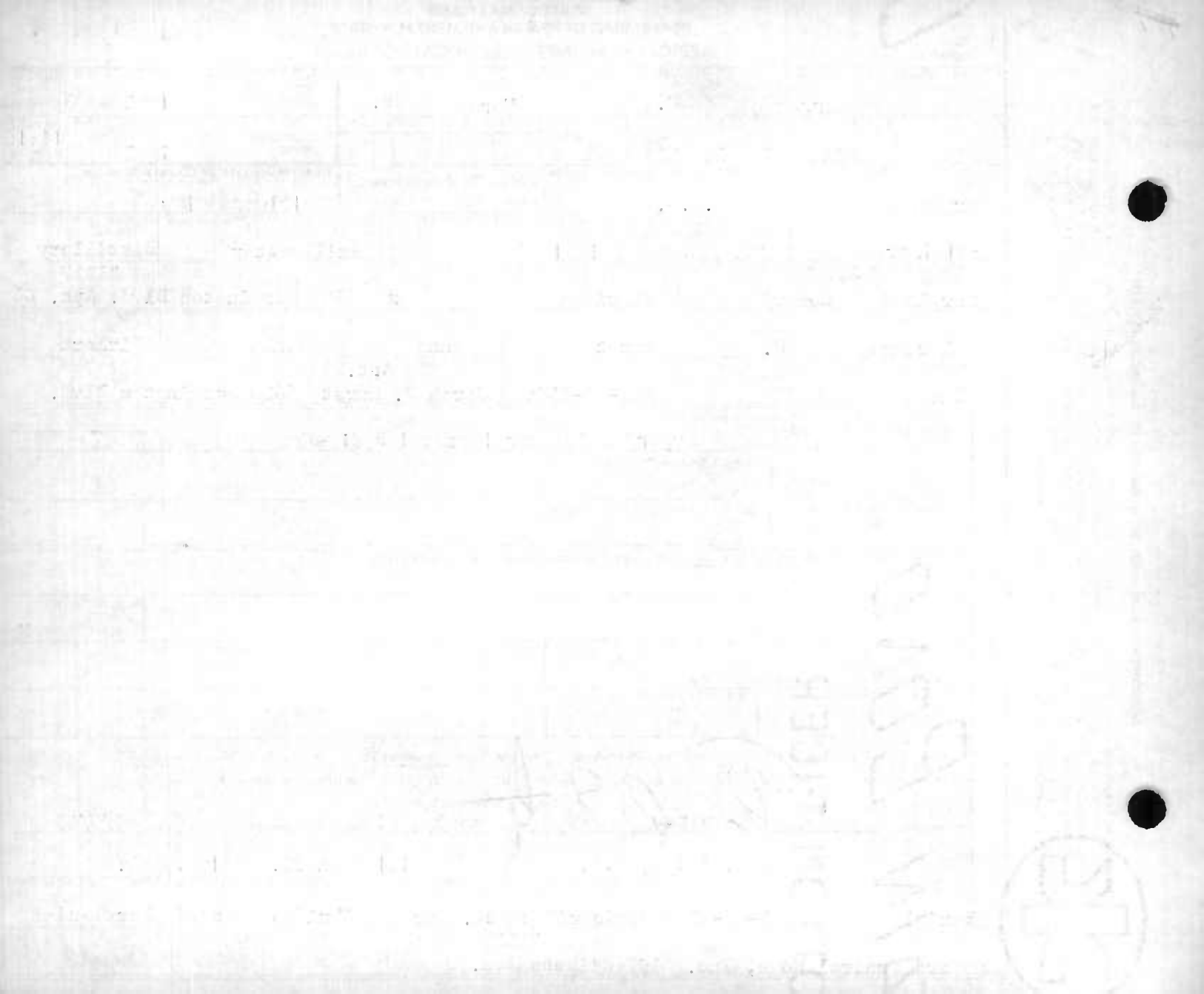
BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |         |   |  |  |  |   |  |  |                                   |   |  |              |
|--|---------|---|--|--|--|---|--|--|-----------------------------------|---|--|--------------|
| 1- FOR STATE REGISTRAR   |         | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 1 2 19 83                    |  |  |  |   |  |  |                                   |   |  | 2b. HOUR a M |
| 1. DECEASED NAME (TYPE OR PRINT)   |         | FIRST   |  | MIDDLE   |  | LAST  |  | Warren C. Hurst Sr.  |                                   |   |  |              |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YR. MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.  |                                   | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR |  | 7d. HOUR a M |
| Male   | White   | 05 18 21  |  | 61 YRS.  |  |   |  |  |                                   | 1 2 19 83                               |  | 11:15 a M    |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |                                   |   |  |              |
| Maryland   |         | U.S.A.  |  |  |  | Baltimore City, MD.   |  |  |                                   |   |  |              |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |              |
| Baltimore  |         | St. Agnes Hospital  |  |  |  | Stillmaster   |  |  | Distillery                        |   |  |              |
| 13a. STATE   |         |   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | 13e. STREET ADDRESS                     |  |              |
| Maryland   |         | Howard  |  | Elkridge   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  | 6620 Washington Blvd. Apt. D4  |                                   |   |  |              |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |         |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |   |  |  |                                   |   |  |              |
| Clarence W. Hurst  |         |   |  | Anna Menke Eirhart   |  |   |  |  |                                   |   |  |              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |         |   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS  |                                   |   |  |              |
| Yes  |         |   |  | WW II  |  | 220-07-1360   |  | Sarah V. Hurst   |                                   | 6620 Washington Blvd.                   |  |              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |   |  |  |  |   |  |  |                                   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |              |
| PART I DEATH WAS CAUSED BY:  |         |   |  |  |  |   |  |  |                                   |   |  |              |
| 4029 IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease   |         |   |  |  |  |   |  |  |                                   |   |  |              |
| DUE TO, OR AS A CONSEQUENCE OF   |         |   |  |  |  |   |  |  |                                   |   |  |              |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  |         |   |  |  |  |   |  |  |                                   |   |  |              |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |         |   |  |  |  |   |  |  |                                   |   |  |              |
| (c)  |         |   |  |  |  |   |  |  |                                   |   |  |              |
| PART 2 OTHER SIGNIFICANT CONDITIONS (CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1)   |         |   |  |  |  |   |  |  |                                   |   |  |              |
| 19a. DATE OF OPERATION   |         |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |                                   |   |  |              |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |                                   |   |  |              |
|  |         |   |  | P.M. 19  |  |   |  |  |                                   |   |  |              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |         |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |  |                                   |   |  |              |
|  |         |   |  |  |  |   |  |  |                                   |   |  |              |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |   |  |  |  |   |  |  |                                   |   |  |              |
| 22b. I certify that I took charge of the remains described above, held on death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |   |  |  |  |   |  |  |                                   |   |  |              |
| ACTUAL SIGNATURE   |         |   |  | THOMAS D. SMITH, M.D. Deputy Chief   |  |   |  | DATE SIGNED 1/3/83   |                                   |   |  |              |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |   |  | ADDRESS  |  |   |  |  |                                   |   |  |              |
| Thomas D. Smith, M.D.  |         |   |  | 111 Penn St. Balto., MD.   |  |   |  |  |                                   |   |  |              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                                       |  |  |                                   |   |  |              |
| Burial   |         | 01-05-83  |  | Meadowridge Mem. Park  |  | Elkridge Howard Maryland  |  |  |                                   |   |  |              |
| 24. FUNERAL DIRECTOR NAME  |         |   |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |                                   |   |  |              |
| Hubbard Funeral Home, Inc.   |         |   |  | 4107 Wilkens Ave.  |  | JAN 5 1983  |  | John J. Givier   |                                   |   |  |              |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3, 4, AND 5 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                      |  |  |  |   |  |  |                            | REG. NO. 3 3 0 1 0 4 5   |  |
|---|--|----------------------|--|--|--|---|--|--|----------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>NATINA HURTE</b>   |  |                      |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>1-30-83</b> |  | 2b. HOUR <b>12:29</b>  |                            | 2c. MONTH <b>1</b> DAY <b>30</b> YEAR <b>83</b>                                  |  |
| 3. SEX <b>FEMALE</b>  |  | 4. RACE <b>BLACK</b> |  | 5. DATE OF BIRTH<br>MONTH <b>8</b> DAY <b>7</b> YEAR <b>1975</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>7</b> YRS.   |  | IF UNDER 1 YR. MONTHS <b>XX</b> DAYS <b>XX</b>   |                            | 7c. DATE PRONOUNCED DEAD <b>1-30-83</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>   |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>US</b>   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>                       |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Good Samaritan Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>STUDENT</b>   |                            | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE <b>MARYLAND</b>  |  |                      |  | 13b. COUNTY <b>BALTIMORE</b>   |  | 13c. CITY OR TOWN <b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |                            | 13e. STREET ADDRESS <b>1613 NORTHWICK ROAD 21212</b>                             |  |
| 14. FATHER'S NAME<br>FIRST <b>CURTIS</b> MIDDLE <b>HURTE</b> LAST <b>HURTE</b>  |  |                      |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>ALICE</b> MIDDLE <b>JONES</b> LAST <b>JONES</b>   |  |   |  |  |                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>  |  |                      |  | 16b. SOCIAL SECURITY NO. <b>216-94-3190</b>  |  | 17. INFORMANT <b>CURTIS HURTE</b>   |  |  |                            | ADDRESS <b>1613 NORTHWICK ROAD</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>5602</b> IMMEDIATE CAUSE (a) <b>Gangrene</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>} <b>volvulus</b><br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)   |  |                      |  |  |  |   |  |  |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                      |  |  |  |   |  |  |                            |  |  |
| 19a. DATE OF OPERATION  |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |  |                            | 20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                 |  |  |                            |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                            |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |                      |  |  |  |   |  |  |                            |  |  |
| ACTUAL SIGNATURE <b>Margarita A. Koroll</b>   |  |                      |  |  |  | TITLE (SPECIFY) <b>Assistant</b>  |  |  | DATE SIGNED <b>1-30-83</b> |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Koroll, M. d.</b>   |  |                      |  |  |  | ADDRESS <b>111 Penn Street</b>  |  |  |                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  |                      |  | 23b. DATE <b>2-5-83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>HURTE FAMILY CEMETERY</b>   |  |  |                            | 23d. LOCATION<br>CITY OR TOWN <b>CREWE</b> COUNTY <b>VIRGINIA</b> STATE          |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>E.L. PHILLIPS</b> ADDRESS <b>1721 N. MONROE ST.</b>   |  |                      |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 10 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>  |                            |  |  |

BP

RECEIVED  
JAN 10 1964  
U.S. AIR FORCE  
HONOLULU, HAWAII



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

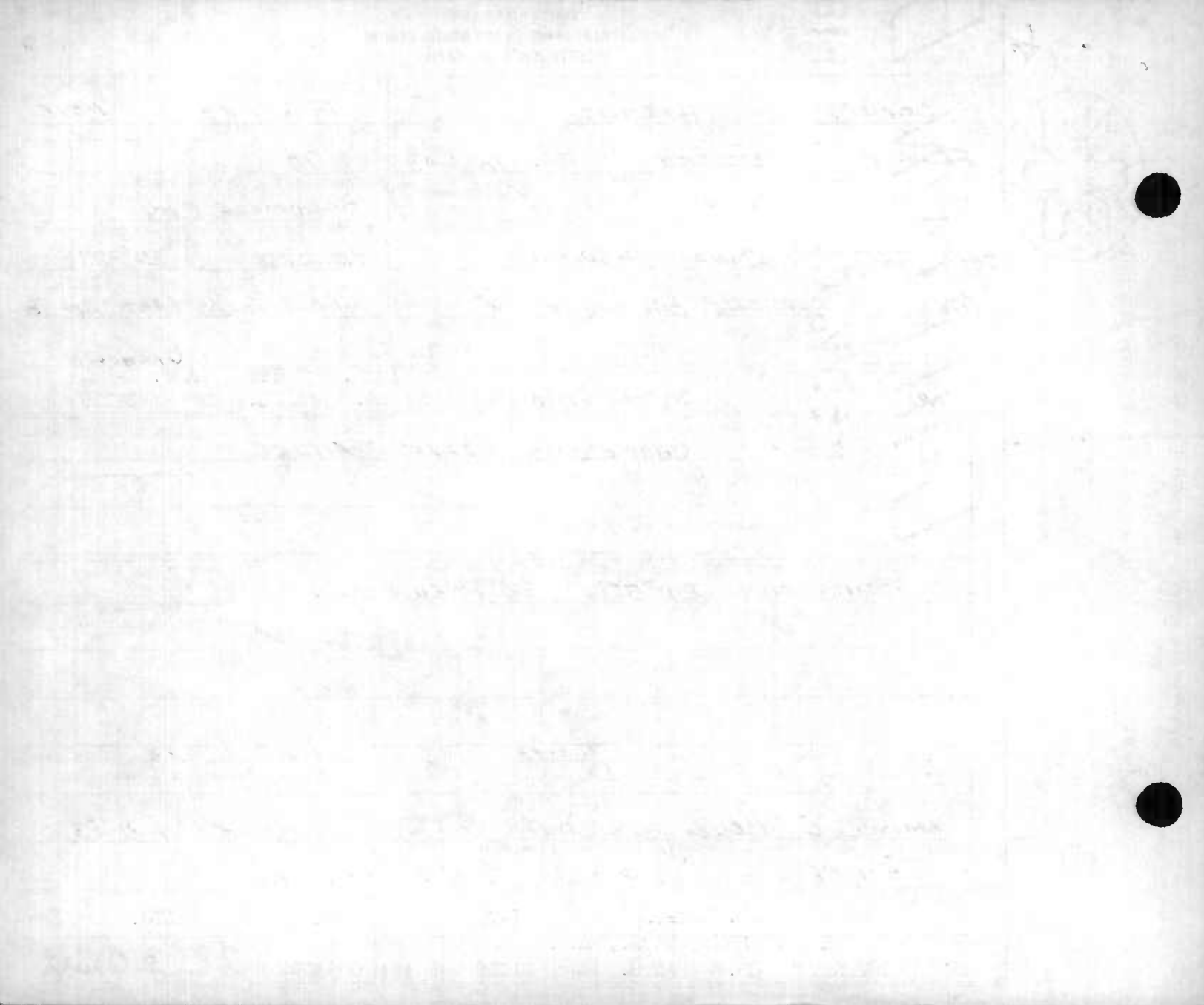
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 172 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  | REG. NO. 83 01046  |   |  |   |  |  |
|--|--|--|--|---|--|--|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>SOPHIA HURWITZ   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>1-21-83                    |  |   |  | 2b. HOUR<br>1:53 P.M.                         |  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>AUG. 10 03  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS  |   | IF UNDER 1 YEAR<br>MONTHS DAYS   |   | IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>AUSTRIA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALT. XXXX  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI HOSPITAL |  |   |  | 12. TYPE OF WORK FOR MOST OF WORKING (LIFE)<br>BOOKKEEPER  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>LAUNDRY   |   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br>MD   |  |  |  |   | 13c. CITY OR TOWN<br>BALTIMORE                                 |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>4004 FORDS LANE Apt 7B |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>BERNARD FINK   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>KATIE UNKNOWN |  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  |  |  |   | 16b. SOCIAL SECURITY NO.<br>215-03-6212                        |  | 17. INFORMANT DAVID S. HURWITZ APT. T-B   |  |   |  |  |
|  |  |  |  |   | 4004 FORDS LA.   |  | BALTO., MD  |  | 21215   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4280 CONGESTIVE HEART FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |   |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>PULMONARY EMBOLI & PNEUMONIA  |  |  |  |   |  |  |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-3-83, 1983, to 1-21-83, 1983, that (I) (we) lost<br>saw the deceased alive on 1-21-83, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                      |  |  |  |   |  |  |   |  |   |  |  |
| 22b. SIGNATURE<br>Jerome E. Covington MD<br>PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>1-21-83  |   |  |  |
| 22d. ADDRESS<br>JEROME E. COVINGTON SINAI HOSPITAL   |  |  |  |   |  |  |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |  |  | 23b. DATE<br>JAN. 23, 1983  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>PETACH TIKVAH  |   | 23d. LOCATION<br>ROSEDALE BALTO. MD  |   |  |  |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC.<br>NAME ADDRESS<br>6010 REISTERSTOWN RD. BALTO., MD 21215  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 26 1983   |   | 25b. REGISTRAR'S SIGNATURE<br>Jerome E. Covington                                    |   |  |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 0 4 7

REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Doris Hutchings   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>01 20 83   |   | 2b. HOUR<br>11:15AM  |  |
| 3. SEX<br>Female   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 6 1920  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>62  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Md.  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                      |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Salesman                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>May Co. |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.  |   | 13b. CITY OR TOWN<br>Talbot   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br>Box 126 (21676)   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Talbot Rollette  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mabel Tyler  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |   | 16b. SOCIAL SECURITY NO.<br>220-09-4461   |   | 17. INFORMANT ADDRESS<br>Merl Hutchings (same as 13e)                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>4275 IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) [did] [did not] view the body after death.)  |   |   |   |  |  |
| 22b. SIGNATURE<br><u>Robert T. Schreiber</u>   |   | DEGREE<br>MD<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |   | 22c. DATE SIGNED<br>1/20/83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert T. Schreiber   |   | 22e. ADDRESS<br>Baltimore City Hospital, Baltimore, Md.   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |   | 23b. DATE<br>1/21/83  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Mem.                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>George J. Gome   |   | 24. ADDRESS<br>Balto., Md. 21225  |   | 25a. DATE REC'D. BY REGISTRAR<br>21 1983                                       |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>John J. Canfield</u>  |   |   |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |  |                                     |  |  |  |                 |  |   |  |  |  |   |  |   |  |   |  |   |  |                   |  |   |  |
|--|--|-------------------------------------|--|--|--|-----------------|--|---|--|--|--|---|--|---|--|---|--|---|--|-------------------|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 2. DECEASED NAME<br>(TYPE OR PRINT) |  | FIRST<br>DELIA   |  | MIDDLE<br>SUBER |  | LAST<br>(HYLER)   |  | HYER   |  | 2a. DATE KNOWN<br>OF DEATH<br>ESTIMATED<br>1-6-83   |  | 19  |  | 2b. HOUR<br>M                                       |  |   |  |                   |  |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Black                    |  | 5. DATE OF BIRTH<br>MONTH<br>5   |  | DAY<br>12       |  | YEAR<br>1894  |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>YRS.<br>88 |  | IF UNDER 1 YR.<br>MONTHS<br>DAYS  |  | IF UNDER 24 HRS.<br>HOURS<br>MIN.   |  | 7c. DATE<br>PRONOUNCED<br>DEAD<br>1-6-83            |  | 19  |  | 2d. HOUR<br>8:56A |  | M |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>South Carolina   |  |                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |                 |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City  |  |   |  |   |  |   |  | MD.               |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                                     |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2401 W. Lanvale Street |  |                 |  |   |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)                                |  |   |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY                |  |   |  |                   |  |   |  |
| 13a. STATE<br>Maryland   |  |                                     |  | 13b. COUNTY  |  |                 |  | 13c. CITY OR TOWN<br>Baltimore  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  | 13e. STREET ADDRESS<br>2401 W. Lanvale Street 21216 |  |   |  |                   |  |   |  |
| 14. FATHER'S NAME<br>Jim   |  |                                     |  | MIDDLE<br>Suber  |  |                 |  | LAST  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>Martha  |  |   |  | MIDDLE<br>Thomas                                    |  |   |  | LAST              |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |                                     |  | (IF YES, GIVE WAR OR DATES)  |  |                 |  | 16b. SOCIAL SECURITY NO.<br>N/A   |  |  |  | 17. INFORMANT<br>Ernest C. Long 79 Pling St. Hartford, Conn                                     |  |   |  |   |  |   |  |                   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (Arteriosclerotic cardiovascular disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |  |                                     |  |  |  |                 |  |   |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |                   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                                     |  |  |  |                 |  |   |  |  |  |   |  |   |  |   |  |   |  |                   |  |   |  |
| 19a. DATE OF OPERATION   |  |                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |                 |  |   |  |  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |   |  |                   |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |   |  |   |  |   |  |   |  |                   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                                     |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |  |                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |   |  |   |  |   |  |                   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                                     |  |  |  |                 |  |   |  |  |  |   |  |   |  |   |  |   |  |                   |  |   |  |
| ACTUAL<br>SIGNATURE<br>H. S. Guard   |  |                                     |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER   |  |                 |  |   |  |  |  |   |  | DATE<br>SIGNED 1-6-83   |  |   |  |   |  |                   |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Hormez R. Guard, M.D.  |  |                                     |  | ADDRESS<br>111 Penn Street   |  |                 |  |   |  |  |  |   |  |   |  |   |  |   |  |                   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |                                     |  | 23b. DATE<br>1/8/83  |  |                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Memorial Park   |  |  |  | 23d. LOCATION<br>CITY OR TOWN<br>Arbutus, Maryland  |  |   |  | COUNTY<br>STATE                                     |  |   |  |                   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March Funeral Home, Inc./1101 E. North Ave.   |  |                                     |  |  |  |                 |  |   |  | 25a. DATE<br>JAN 10 1983                         |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>J. A. J. Canfield                                     |  |   |  |   |  |                   |  |   |  |



JAN 10 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

UNIT NO. 04855499

|   |  |  |  |
|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>SOL  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 13 83   |  |
| 3. SEX<br>MALE  |  | 2b. HOUR<br>11:58 PM   |  |
| 4. RACE<br>WHITE  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS.   |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>01 23 15  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NEW YORK   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI HOSP OF BALT   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SALESMAN   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>FURNITURE  |  | 13a. STREET ADDRESS<br>21209<br>6421-A ELRAY DRIVE   |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY  |  |
| 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>WILLIAM ISAKOFF   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>NELLIE SCHREBNICK   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES   |  | 16b. SOCIAL SECURITY NO.<br>WWII-ARMY 071-14-6533  |  |
| 17. INFORMANT<br>ADDRESS<br>MRS. RUTH ISAKOFF 6421-A ELRAY DR. 21209  |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>4100 IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) SEVERE ASVD<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/13/83, 1983, to 1/13, 1983, that (I) (we) last saw the deceased alive on 1/13, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |
| 22b. SIGNATURE<br>Harvey Rosen  |  | 22c. DATE SIGNED<br>1/13/83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Harvey Rosen   |  | 22e. ADDRESS<br>SINAI HOSP OF BALT   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>1/16/83   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>MIKRO KODESH CEM.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND   |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 18 1983   |  |
| 25b. REGISTRAR'S SIGNATURE  |  |  |  |

212234-01-7141

10-11-1962

STATE DEPT. OF DEFENSE  
WASHINGTON, D.C.

9





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

01050

|   |         |   |  |   |  |                                   |  |                                      |  |                          |  |       |  |      |  |          |  |
|---|---------|---|--|---|--|-----------------------------------|--|--------------------------------------|--|--------------------------|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST   |  | MIDDLE  |  | LAST                              |  | 2a. DATE KNOWN OF DEATH              |  | MONTH                    |  | DAY   |  | YEAR |  | 2b. HOUR |  |
| Samuel  |         |   |  |   |  | Ison                              |  | X                                    |  | 1                        |  | 13    |  | 19   |  | 83       |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.                    |  | IF UNDER 24 HRS.                     |  | 7c. DATE PRONOUNCED DEAD |  | MONTH |  | DAY  |  | YEAR     |  |
| male  | Black   | 5 3 32  |  | 50 YRS.   |  |                                   |  |                                      |  | 1                        |  | 13    |  | 19   |  | 83       |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?                                |  | 8. MARRIED  |  | NEVER MARRIED                     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |                          |  |       |  |      |  |          |  |
| Maryland  |         | U.S.A.  |  | WIDOWED   |  | DIVORCED                          |  | Baltimore City                       |  |                          |  |       |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |                                      |  |                          |  |       |  |      |  |          |  |
| Baltimore   |         | Church Home Hospital  |  |   |  |                                   |  |                                      |  |                          |  |       |  |      |  |          |  |
| 13a. STATE  |         | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?          |  | 13e. STREET ADDRESS                  |  |                          |  |       |  |      |  |          |  |
| Maryland  |         |   |  | Baltimore   |  | YES X NO                          |  | 4 N. Central Ave. 21202              |  |                          |  |       |  |      |  |          |  |
| 14. FATHER'S NAME   |         | 15. MOTHER'S MAIDEN NAME                                    |  |   |  |                                   |  |                                      |  |                          |  |       |  |      |  |          |  |
| John  |         | Eliza   |  |   |  |                                   |  |                                      |  |                          |  |       |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |         | 16b. SOCIAL SECURITY NO.                                    |  | 17. INFORMANT   |  | ADDRESS                           |  |                                      |  |                          |  |       |  |      |  |          |  |
| No  |         | N/A   |  | Dorothy Morton  |  | 3425 Chessell Ct.                 |  |                                      |  |                          |  |       |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).)  |         | PART 1 DEATH WAS CAUSED BY:                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                  |  |                                   |  |                                      |  |                          |  |       |  |      |  |          |  |
| 4029  |         | IMMEDIATE CAUSE (a)   |  | Hypertensive and Arteriosclerotic Cardiovascular Disease                      |  |                                   |  |                                      |  |                          |  |       |  |      |  |          |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                       |         | (b)   |  | DUE TO, OR AS A CONSEQUENCE OF  |  |                                   |  |                                      |  |                          |  |       |  |      |  |          |  |
|   |         | (c)   |  | DUE TO, OR AS A CONSEQUENCE OF  |  |                                   |  |                                      |  |                          |  |       |  |      |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |         |   |  |   |  |                                   |  |                                      |  |                          |  |       |  |      |  |          |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  | 20. AUTOPSY?  |  |                                   |  |                                      |  |                          |  |       |  |      |  |          |  |
|   |         |   |  | YES X NO  |  |                                   |  |                                      |  |                          |  |       |  |      |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |         | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                                   |  |                                      |  |                          |  |       |  |      |  |          |  |
|   |         | P.M. 19   |  |   |  |                                   |  |                                      |  |                          |  |       |  |      |  |          |  |
| 21d. INJURY OCCURRED WHILE AT WORK  |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION   |  |                                   |  |                                      |  |                          |  |       |  |      |  |          |  |
|   |         |   |  | STREET  |  | CITY OR TOWN                      |  | COUNTY                               |  | STATE                    |  |       |  |      |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from:                                      |         | Autopsy X   |  | Inspection  |  | Inquiry                           |  | and in my opinion                    |  |                          |  |       |  |      |  |          |  |
| Natural causes X  |         | Accident  |  | Suicide   |  | Homicide                          |  | Undetermined manner                  |  |                          |  |       |  |      |  |          |  |
| ACTUAL SIGNATURE  |         | TITLE (SPECIFY)   |  | DATE SIGNED   |  |                                   |  |                                      |  |                          |  |       |  |      |  |          |  |
| Hormez R. Guard   |         | Assistant   |  | 1/13/83   |  |                                   |  |                                      |  |                          |  |       |  |      |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |         | ADDRESS   |  |   |  |                                   |  |                                      |  |                          |  |       |  |      |  |          |  |
| Hormez R. Guard, M.D.   |         | 111 Penn St., Balto, Md.                                    |  |   |  |                                   |  |                                      |  |                          |  |       |  |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |         | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION                     |  | CITY OR TOWN                         |  | COUNTY                   |  | STATE |  |      |  |          |  |
| BURIAL  |         | 1/20/83   |  | Mount Zion Cem.   |  | Baltimore                         |  | Co.                                  |  | Md.                      |  |       |  |      |  |          |  |
| 24. FUNERAL DIRECTOR NAME   |         | 25a. DATE REC'D. BY REGISTRAR                               |  | REGISTRAR'S SIGNATURE   |  |                                   |  |                                      |  |                          |  |       |  |      |  |          |  |
| Wm. C. March F/H Inc.   |         | JAN 17 1983   |  | John J. Connel  |  |                                   |  |                                      |  |                          |  |       |  |      |  |          |  |
| 1101 E. North Ave.  |         |   |  |   |  |                                   |  |                                      |  |                          |  |       |  |      |  |          |  |



REBILITATION

1000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 0 5 1

REG. NO.

|  |  |  |   |  |  |   |  |  |
|--|--|--|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR   |  |  | 2a. DATE OF DEATH   |  |  | 2b. HOUR  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | 2a. DATE OF DEATH   |  |  | 2b. HOUR  |  |  |
| Andrew Jackson Isaac   |  |  | January 22, 1983  |  |  | 6:55A M   |  |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |  | IF UNDER 1 YEAR   |  |  |
| male   | white  | March 7, 1886  | 96 YRS.   |  |  | IF UNDER 24 HRS.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |   |  |  |
| Maryland   | USA  |  | Baltimore City MD.  |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| Baltimore  | Maryland General Hospital  |  | Plasterer   |  |  | Construction  |  |  |
| 13a. STATE   |  |  |   |  |  |   |  |  |
| Md.  |  |  |   |  |  |   |  |  |
| 13b. COUNTY  |  |  | 13c. CITY OR TOWN   |  |  | 13d. INSIDE CITY LIMITS?  |  |  |
|  |  |  | Baltimore   |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME  |  |  |   |  |  |
| Thomas A. Isaac  |  |  | Mary E. Lilley  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT ADDRESS   |  |  |
| no   |  |  | 217 07 3797A  |  |  | Edna Fisher Same  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:  |  |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| 5960 IMMEDIATE CAUSE (a) Sepsis  |  |  |   |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Urinary Tract Infection   |  |  |   |  |  |   |  | ?  |
| DUE TO, OR AS A CONSEQUENCE OF (c) Bladder Obstruction   |  |  |   |  |  |   |  | ?  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|  |  |  |   |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  |  |
|  |  |  | HOUR A.M. MONTH DAY YEAR  |  |  |   |  |  |
| 21d. INJURY OCCURRED   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION   |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  |  |   |  |  | CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 21, 19 83, to January 22, 19 83, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on January 22, 19 83, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE   |  |  | DEGREE  |  |  | 22c. DATE SIGNED  |  |  |
| Mohammad Aslam, M.D.   |  |  | Attending Physician   |  |  | 1/22/83   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  | 22e. ADDRESS  |  |  |   |  |  |
| Mohammad Aslam, M.D.   |  |  | c/o Maryland General Hospital                                       |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE   |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  |
| Burial   |  |  | 1/25/83   |  |  | Woodlawn Cemetery   |  |  |
| 23d. LOCATION  |  |  | 23e. DATE REC'D. BY REGISTRAR                                       |  |  | 23f. REGISTRAR'S SIGNATURE  |  |  |
| Woodlawn Balto. Co. Md   |  |  | JAN 24 1983   |  |  | John J. Connelley   |  |  |
| 24. FUNERAL DIRECTOR   |  |  |   |  |  |   |  |  |
| Burgee Funeral Home 3631 Falls Road 21211  |  |  |   |  |  |   |  |  |

MEDICAL CERTIFICATION



1/25/37  
1/25/37

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1/22/83

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be kept with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at (410) 327-1111.



## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   | 8 3 0 1 0 5 2 |  |
|--|--|--|--|---|---------------|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  |  |   | REG. NO.      |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>STEPHEN JABLKOWSKI</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01/23/83</b>  |               |  |
| 3. SEX<br><b>MALE</b>  |  |  |  | 2b. HOUR<br><b>8:07 PM</b>  |               |  |
| 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 30 - 1900</b>                                |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS.   |               |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>POLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |               |  |
| 9. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                        |  |   |               |  |
| 10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b>   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>STATOPEY ENGR</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |               |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>BALTO</b>  |  | 13c. CITY OR TOWN<br><b>BALTO</b>   |               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ANDREW JABLKOWSKI</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY JABLKOWSKI</b>                  |  | 13d. STREET ADDRESS<br><b>245 S. Washington St</b>  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215-01-1792</b>   |  | 17. INFORMANT<br><b>Donald Jablowski</b>  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4360</b><br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Aspiration Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CVA (R) hemisphere</b>  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>20 mins</b><br><b>24 hrs</b>          |  |   |               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Anticoagulant myocardial infarction</b>  |  |  |  |   |               |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |               |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |   |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                               |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 8</b> , 19 <b>83</b> , to <b>Jan 23</b> , 19 <b>83</b> , that (I) (we) <input checked="" type="checkbox"/> saw the deceased alive on <b>Jan 23</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |               |  |
| 22b. SIGNATURE<br><b>Daniel E. Ford</b>  |  | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>1/23/83</b>  |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DANIEL E. FORD</b>   |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>  |  |   |               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>1-27-83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HOLY REDEEMER</b>  |               |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO</b>   |  |  |  |   |               |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>John M. Weber &amp; Sons Inc. CHESTER</b>   |  | 24a. DATE REC'D. BY REGISTRAR<br><b>JAN 25 1983</b>                                      |  | 24b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |               |  |

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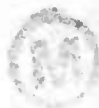
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IN EXECUTING THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL EXAMINER. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |   |                                   | REG. NO. 01053  |  |
|---|--|--|--|--|--|--|--|---|-----------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Erica Elaine Jackson</b>   |  |  |  |  |  |  |  |   |                                   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR <input type="checkbox"/> MIN <input type="checkbox"/> SEC <input type="checkbox"/> |  |
| 3. SEX <b>female</b>  |  | 4. RACE <b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>1 8 77</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY MONTHS DAYS HOURS MIN <b>6 YRS.</b>   |  | IF UNDER 1 YR. IF UNDER 24 HRS.   |                                   | 2c. DATE PRONOUNCED DEAD <b>1 19 19 83</b> <b>PM</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.   |  |   |                                   |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Johns Hopkins Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| 13a. STATE <b>Maryland</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN <b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                         |  | 13e. STREET ADDRESS <b>3029 E. Federal St. 21213</b>                                |                                   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Nelson S. Jackson</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Elaine Medley</b>   |  |  |  |   |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>   |  | (IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO. <b>N/A</b>  |  | 17. INFORMANT ADDRESS <b>Elaine McCorgo 3029 E. Federal St.</b>  |  |   |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: <b>8147 Cranio-cerebral Injury</b><br>IMMEDIATE CAUSE (a) <b>8147</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>(c)<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1  |  |  |  |  |  |  |  |   |                                   |   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  | 21b. TIME OF INJURY<br>HOUR <b>5:15M.</b> MONTH DAY YEAR <b>1 19 1983</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>pedestrian struck by automobile</b> |  |   |                                   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE <b>3100 E. Federal St., Baltimore City, Md.</b>                    |  |   |                                   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |   |                                   |   |  |
| ACTUAL SIGNATURE <b>H R Guard</b>   |  |  |  | TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER  |  |  |  | DATE SIGNED <b>1/20/83</b>  |                                   |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>  |  |  |  | ADDRESS <b>111 Penn St., Balto, Md.</b>  |  |  |  |   |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  |  |  | 23b. DATE <b>1/24/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Westview MEm. Pk.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Baltimore Co. Md.</b>                 |                                   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS <b>Wm. C. March F/H 1101 E. North avenue</b>   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 21 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Canfield</b>                                  |                                   |   |  |





AMERICAN  
RED CROSS

WASH  
D.C.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 01054

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |   |   |  |   |                            |  |
|---|---|---|--|---|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST <u>MILTON</u> MIDDLE <u>E</u> LAST <u>JACKSON</u><br><u>JACKSON MILTON JACKSON</u> |   |   | 2a. DATE OF DEATH<br>MONTH <u>1</u> DAY <u>24</u> YEAR <u>83</u> |   | 2b. HOUR<br><u>3:19</u> AM |  |
| 3. SEX<br><u>M</u>  | 4. RACE<br><u>B</u>   | 5. DATE OF BIRTH<br>MONTH <u>7</u> DAY <u>10</u> YEAR <u>45</u>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>37</u> YRS.   |                            | IF UNDER 1 YEAR<br>MONTHS <u></u> DAYS <u></u> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Maryland</u>  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore City</u> MD                                |                            |  |
| 10. CITY OR TOWN OF DEATH<br><u>Baltimore</u>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>University Hospital</u> |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |                            | 12b. KIND OF BUSINESS OR INDUSTRY              |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><u>Maryland</u>   |   | 13b. CITY OR TOWN<br><u>Baltimore</u>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                            |  |
| 14. FATHER'S NAME<br>FIRST <u>Alton</u> MIDDLE <u></u> LAST <u>Jackson</u>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <u>Mildred</u> MIDDLE <u>Ethel</u> LAST <u>Skinner</u>  |  |   |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <u>No</u>  |   | 16b. SOCIAL SECURITY NO.<br><u>219-40-4240</u>  |  | 17. INFORMANT<br>ADDRESS<br><u>Arthurine Ingram 1826 Maulsby Ct.</u>                            |                            |  |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br><u>5188</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Diffuse Pulmonary Interstitial Disease</u><br>2 days<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>1 Hour</u> |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Osteogenic Sarcoma

|  |  |  |   |
|--|--|--|---|
| 19a. DATE OF OPERATION<br><u>1/19/83</u>   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>AKA for pain relief</u> | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>P.M.</u> <u>19</u>       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)         | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |

22a. I certify that (I) (this hospital) attended the deceased from 1/23 19 83 to 1/24 19 83 that (I) (we) last  
saw the deceased alive on 1/24 19 83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

|  |                     |  |                                    |
|--|---------------------|--|------------------------------------|
| 22a. SIGNATURE<br><u>David Patz</u>                        | DEGREE<br><u>MD</u> | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br><u>1/24/83</u> |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>DAVID PATZ</u> |                     | 22d. ADDRESS<br><u>Univ. Hospital, Balto MD. 21201</u>   |                                    |

|   |                             |  |  |
|---|-----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>BURIAL</u> | 23b. DATE<br><u>1/27/83</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mount Zion Cem.</u> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Baltimore Co. Md.</u> |
|---|-----------------------------|--|--|

|   |   |   |
|---|---|---|
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Wm. C. March F/H Inc. 1101 E. North Ave,</u> | 25a. DATE REC'D. BY REGISTRAR<br><u>25 1983</u> | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Carver</u> |
|---|---|---|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B show any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten notes at the top of the page, including a date "1941" and some illegible text.

Main body of handwritten notes on lined paper, covering the middle section of the page.

Handwritten notes at the bottom of the page, including a date "1941" and some illegible text.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 3 0 1 0 5 5   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  | 2b. HOUR   |  |
| THEODORE R. JACKSON  |  |   |  | JANUARY 4, 1983   |  |   |  | 9:41 AM  |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| Male   |  | Cau.  |  | 10 29 13  |  | 69 YRS.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |
| Phillipines  |  | U.S.A.  |  |   |  | Balto. City MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| Balto.   |  | Church Hosp.  |  | Merchant Seaman   |  | Retired   |  |  |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |  | 13e. STREET ADDRESS  |  |
| Md.  |  | Balto.  |  | Balto.  |  |   |  | 13107 Patuxent Rd. 21220   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |   |  |  |  |
| unknown  |  |   |  | unknown   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>ADDRESS  |  |  |  |
| no   |  |   |  | 549-24-9540   |  | Dee D. Liersemann 13107 Patuxent Rd.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) PROBABLE MYOCARDIAL INFARCTION<br>+960<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) CHRONIC OBSTRUCTIVE PULMONARY DISEASE<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) PNEUMONIA |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from<br>JANUARY 4 1983, to JANUARY 4 1983, that (1) (we) last<br>saw the deceased alive on above, (1) (we) (did not) view the body after death, and that in (my (our)) opinion death occurred on the date and hour and from the causes stated  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Walker A Impagliatelli</i>  |  |   |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WALKER A IMPAGLIATELLI, M.D.  |  |   |  | 22e. ADDRESS<br>CHURCH HOSPITAL<br>100 NORTH BROADWAY, BALTIMORE, MD 21231  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |  |  |
| Burial   |  | 1-6-83  |  | Holly Hill Cem.   |  | Balto. Balto. Md.   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |  |   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| John C. Miller Inc. 6415 Belair Rd.  |  |   |  | JAN 10 1983   |  | <i>John J. Carrel</i>   |  |  |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8301056  |  |
|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>WILLIE</b>  |  | 2a. DATE OF DEATH MONTH <b>1</b> DAY <b>29</b> YEAR <b>83</b>   |  | 2b. HOUR <b>6:10 PM</b>  |  |
| 3 SEX <b>Male</b>   |  | 4 RACE <b>Negro</b>   |  | 5. DATE OF BIRTH MONTH <b>1</b> DAY <b>1</b> YEAR <b>23</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Charlotte, N.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore City</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2829 W. Garrison Avenue</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Dry Cleaning of Clothes</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE <b>Maryland</b>  |  | 13b. COUNTY <b>Baltimore</b>  |  | 13c. STREET ADDRESS <b>2829 W. Garrison Ave</b>  |  |
| 14. FATHER'S NAME FIRST <b>Willie</b> MIDDLE <b>Proctor</b> LAST <b>Jackson</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Lucille</b> MIDDLE <b>Satcher</b> LAST <b>Ave.</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO. <b>299-18-9668</b>   |  | 17. INFORMANT ADDRESS <b>Dorothy P. Jackson 2829 W. Garrison</b>                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cachexia - Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Wide Spread Metastatic Bone Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Adenocarcinoma Prostate - Stage DII</b> 11/5/80                            |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |  |  |  |
| 19a. DATE OF OPERATION <b>Oct 1977</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Obstructive Urothology</b>  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                      |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                         |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>Nov 5</b> , 19 <b>83</b> , to <b>Jan 29</b> , 19 <b>83</b> , that (I) (we) saw the deceased alive on <b>Jan 26</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |
| 22b. SIGNATURE <b>Leonard H. Flax, M.D.</b> DEGREE <b>M.D.</b>  |  | 22c. DATE SIGNED <b>1/30/83</b>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Leonard H. Flax, M.D.</b>                                     |  |
| 22e. ADDRESS <b>8917 Liberty Rd. Randallstown, Md. 21133</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  | 23b. DATE <b>2/1/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Mount Auburn Cem.</b>  |  |
| 23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>Md.</b>   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H Inc.</b> ADDRESS <b>1101 E. North Avenue</b>  |  | FEB 1983  |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 3 0 1 0 5 7   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1 - FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MA JACOB O. JACOBS</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 20, 1983</b>  |  | 2b. HOUR<br><b>11:50<sup>P</sup><sub>M</sub></b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Cauc.</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 4 1890</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>92</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Steel Worker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Steel</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b> 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  | 13e. STREET ADDRESS<br><b>2616 Orleans St. 21224</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br><b>213-07-3088</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>John Jacobs 2616 Orleans St.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1950</b> IMMEDIATE CAUSE (a) <b>PROSTATIC CARCINOMA</b>   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>MONTHS</b>  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____   |  |   |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JANUARY 18, 1983</b> to <b>JANUARY 20, 1983</b> , that (I) (we) last saw the deceased alive on <b>JANUARY 20, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, (I) (did) (and not view the body after death). |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Paul Gormley</i>   |  |   |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>1/20/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PAUL GORMLEY M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION<br/>100 N. BROADWAY BALTIMORE, MARYLAND 21231</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/24/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cem</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>B. Dabrowski &amp; Son 2818 E. Baltimore St.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 25 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Canine</i>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please reattach to the original. Pages 1 and 2 should be retained 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |   |  | 8 3 0 1 0 5 3  |  |   |  |
|--|--|---|--|---|--|---|--|---|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.  |  |   |  |   |  |   |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>Ruth   |  | MIDDLE<br>N.  |  | LAST<br>Jacobs  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>1 22 83   |  |  |  | 2b. HOUR<br>11 40 AM  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>05 07 34  |  |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>48 YRS   |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>USA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD   |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Balt  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Univ. of Md. Hosp. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CASHIER   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Govt (STATE)                          |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE Maryland   |  | 13b. COUNTY<br>Balt   |  | 13c. CITY OR TOWN<br>Balt   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>6140 LAVAL AVE (20706)   |  |  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Kate Warner  |  |   |  |   |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>232-54-4353   |  | 17. INFORMANT<br>ADDRESS<br>William Jacobs (Same as #13)  |  |   |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>2050 IMMEDIATE CAUSE (a) Acute myelo-monocytic leukemia<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) pneumonia<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) renal failure                                       |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>6 mos<br>12 wks<br>1 wk |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/5 19 83, to 1/22 19 83, that (I) (we) lost<br>saw the deceased alive on 1/22 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>Jeffrey Abrams   |  | DEGREE<br>MD  |  |   |  | ATTENDING<br>PHYSICIAN <input type="checkbox"/> MEDICAL<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYSICIAN <input checked="" type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br>1/22/83  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jeffrey Abrams  |  | 22e. ADDRESS<br>20 S. Greene St. Balt, Md.  |  |   |  |   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>26 JAN 83  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MD Veterans Cemetery  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cheltenham Md. Prince Georges Co. Md.   |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Howard H. Hartz  |  | ADDRESS<br>4425 Lanham FH. 9015 4th Ave. MD   |  |   |  | 25a. DATE RECEIVED BY REGISTRAR<br>FEB 1 1983   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |   |  |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 0 5 9

1- FOR  
STATE  
REGISTRAR

Lucy James

REG. NO.

|   |  |  |   |   |  |   |  |  |  |
|---|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Lucy James</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1/ 15/ 1983</b> |   |  | 2b. HOUR<br><b>8:20P</b>  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1/ 31/ 1907</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Melchor Nursing Home</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>laundress</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>21225 301 Key Avenue Baltimore, Md.</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>unknown</b>  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>unknown</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>214-74-6153M</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Office On Aging 301 W. Preston Street</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest ASCVD</b><br><b>4280</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>dementia</b><br>DUE TO, OR AS A CONSEQUENCE OF |  |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/81</b> , 19 <b>81</b> , to <b>1/15</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>12/30</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>M. Shanohy MD</b>  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><b>1/16/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M. Shanohy</b>  |  |  |   | 22e. ADDRESS<br><b>1205 St Paul St 21202</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>1/19/83</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Zion Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. Md.</b>                          |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H Inc. 1101 E. North Avenue</b>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 19 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>   |  |  |  |

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                  |  |  |  |   |   |  |  |  | REG. NO. 8 3 0 1 0 6 0 |  |
|--|------------------|--|--|--|---|---|--|--|--|------------------------|--|
| 1- FOR STATE REGISTRAR<br>DECEASED NAME (TYPE OR PRINT) <b>Leonard Janiszewski</b>   |                  |  |  |  |   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>1</b> DAY <b>19</b> YEAR <b>1983</b> |  | 2b. HOUR <b>9:02</b>   |  |                        |  |
| 3. SEX <b>M</b>  | 4. RACE <b>W</b> | 5. DATE OF BIRTH MONTH <b>Aug</b> DAY <b>23</b> YEAR <b>1967</b>   | 6. AGE (IN YEARS) LAST BIRTHDAY <b>67</b> YRS. | IF UNDER 1 YR. MONTHS _____ DAYS _____   | IF UNDER 24 HRS. HOURS _____ MIN. _____ | 2c. DATE PRONOUNCED DEAD MONTH <b>1</b> DAY <b>19</b> YEAR <b>1983</b>                                    |  | 2d. HOUR <b>9:02</b>   |  |                        |  |
| 7a. BIRTH PLACE (STATE OR IN COUNTRY) <b>Baltimore</b>   |                  | 7b. CITIZENSHIP OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.  |  |  |  |                        |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospital</b> |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK) <b>Nurse Operator</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                        |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Md.</b> CITY OR TOWN <b>Hartford</b>  |                  | 13b. CITY OR TOWN <b>Edgewood</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS <b>606 Albrecht Drive</b> <b>21040</b>  |  |  |  |                        |  |
| 14. FATHER'S NAME FIRST <b>Augusta</b> MIDDLE <b>Janisewski</b> LAST <b>Janiszewski</b>  |                  |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Sophia</b> MIDDLE <b>W</b> LAST <b>Janiszewski</b>   |   |   |  |  |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b>  |                  | 16b. SOCIAL SECURITY NO. <b>111-111111</b>   |  | 17. INFORMANT ADDRESS <b>Josephine H. Droll 739 S. Bock</b>  |   |   |  |  |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>9571</b> IMMEDIATE CAUSE (a) <b>Multiple injuries</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                    |                  |  |  |  |   |   |  |  |  |                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |                  |  |  |  |   |   |  |  |  |                        |  |
| 19a. DATE OF OPERATION   |                  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |                        |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  | 21b. TIME OF INJURY HOUR <b>8:09</b> MONTH <b>1</b> DAY <b>19</b> YEAR <b>1983</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>subject jumped from 3rd floor balcony</b>                               |   |   |  |  |  |                        |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Parking lot</b>   |  | 21f. LOCATION STREET <b>Holiday Inn, 3600 Pulaski Hwy.</b> CITY OR TOWN <b>Balto.,</b> COUNTY <b>Md.</b> STATE <b>Md.</b>                                |   |   |  |  |  |                        |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                  |  |  |  |   |   |  |  |  |                        |  |
| ACTUAL SIGNATURE <b>H. R. Guard</b>  |                  | M.D. <b>Assistant</b>  |  |  |   | MEDICAL EXAMINER DATE SIGNED <b>1/20/83</b>   |  |  |  |                        |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>   |                  | ADDRESS <b>111 Penn St., Balto, Md.</b>  |  |  |   |   |  |  |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>  |                  | 23b. DATE <b>1/23/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>  |   |   |  | 23d. LOCATION CITY OR TOWN <b>Fort Belvoir</b> COUNTY <b>Jefferson</b> STATE <b>Missouri</b> |  |                        |  |
| 24. FUNERAL DIRECTOR <b>Charles S. Stevens</b>   |                  | DATE REC'D. BY REGISTRAR <b>JAN 21 1983</b>  |  | REGISTRAR'S SIGNATURE <b>John J. Gahagan</b>   |   |   |  |  |  |                        |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 7 and 8 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as required on page 4.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 8301061  |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HELEN K. JANOWSKI</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JANUARY 20, 1983</b>   |  | 2b. HOUR<br><b>1:11 PM</b>   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 21 1905</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CHURCH HOME &amp; HOSP</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>LABORER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>PACKING HOUSE</b>  |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>BALTO</b>  |  | 13c. CITY OR TOWN<br><b>BALTO</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN KROL</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SOPHIE SKOWRONSKI</b>  |  | 13e. STREET ADDRESS<br><b>1716 LANCASTER ST</b> 21231   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218-07-3700</b>   |  | 17. INFORMANT ADDRESS<br><b>STEPHEN JANOWSKI 517 S. ARLIN ST</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>THROMBOEMBOLISM</b><br>(c) <b>CARDIAC ARRHYTHMIA</b><br><b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE WITH</b> |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>DECEMBER 26</b> , 19 <b>82</b> , to <b>JANUARY 20</b> , 19 <b>83</b> , that (I) (we) <b>lost</b> saw the deceased alive on <b>JANUARY 20</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Melito M. Torres</i>   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>1/20/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MELITO M. TORRES, M.D.</b>  |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL<br/>100 NORTH BROADWAY, BALTIMORE, MD 21231</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>1-25-83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HOLY ROSARY</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO MD</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>JOHN M. WEBER &amp; SONS INC. CHESTER</b>  |  | 24b. DATE REC'D. BY REGISTRAR<br><b>JAN 25 1983</b>  |  | 24c. REGISTRAR'S SIGNATURE<br><i>John J. Conner</i>   |  |  |  |

BP

RECEIVED  
JAN 10 1964

TO: DIRECTOR, AGRICULTURAL RESEARCH SERVICE  
FROM: [illegible]  
SUBJECT: [illegible]  
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report containing several paragraphs of text, possibly discussing agricultural research findings or administrative matters. Some words like "concerning", "the", "and", "which" are faintly visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 83 01062   |  |  |  |
|---|--|---|--|--|--|--|--|
| FOR<br>1. STATE<br>REGISTRAR  |  |   |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GEORGE H JARRELL</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 26 83 930AM   |  |  |  |
| 3 SEX <b>MALE</b>   |  | 4 RACE <b>White</b>   |  | 5 DATE OF BIRTH <b>Feb. 2 1915</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>67</b>   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>  |  | 7b CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD</b>   |  |
| 10 CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Baltimore Gen Hosp</b> |  | 12a USUAL OCCUPATION (TYPE OF WORK) <b>PAID ROAD</b>   |  | 12b KIND OF BUSINESS OR INDUSTRY   |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b STATE <b>MD</b> 13c COUNTY <b>BALTA</b> 13d CITY OR TOWN <b>Baltimore</b>  |  | 13e INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13f STREET ADDRESS <b>405 Magnolia Road Su</b>   |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST <b>CLIFTON</b>   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ELIZABETH FOX</b>  |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  |  |  |
| 16b SOCIAL SECURITY NO. <b>579 01354</b>  |  | 17 INFORMANT NAME ADDRESS <b>JEFFREY M GRECO South Bt Gen Hosp</b>  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4100 IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CORONARY ARTERY DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>SEIZURE DISORDER, PSORIASIS, PACE MAKER INSERTED - Sick SINUS RATE</b>  |  |   |  |  |  |  |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11/18/83</b>   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK   |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>1/18/83</b> to <b>1/26/83</b> , that (I) (we) last saw the deceased alive on <b>1/26/83</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |  |  |
| 22b SIGNATURE <b>Jeffrey M Greco</b>  |  |   |  | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>          |  | 22c DATE SIGNED <b>1/26/83</b>   |  |
| 22d PHYSICIAN NAME (TYPE OR PRINT) <b>JEFFREY M GRECO</b>   |  |   |  | 22e ADDRESS <b>South Bt Gen Hosp.</b>  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL SPECIFY <b>Burial</b>  |  | 23b DATE <b>29 Jan 83</b>   |  | 23c NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Pk.</b>  |  | 23d LOCATION CITY OR TOWN COUNTY STATE <b>Elkridge Howard MD</b>   |  |
| 24 FUNERAL DIRECTOR NAME <b>James S. Kirkley, Glen Burnie, MD</b>   |  |   |  | 25a DATE REG. BY REGISTRAR <b>JAN 28 1983</b>  |  | 25b REGISTRAR'S SIGNATURE <b>John J. [Signature]</b>   |  |

BP \_\_\_\_\_



George H. 11/22/83

MD 12/12/83

MD 12/12/83

MD 12/12/83

MD 12/12/83

MD 12/12/83

MD 12/12/83

MD 12/12/83

MD 12/12/83

MD 12/12/83

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8301063

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>VIRGINIA S JASKIEWICZ  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>01 17 1983<br>2b. HOUR<br>12:26 PM                       |  |  |
| 3. SEX<br>Female  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 18, 1926  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>56 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Home Maker                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-----                       |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |   |   | 13b. COUNTY<br>-----  |  |  |
| 13c. CITY OR TOWN<br>Baltimore  |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frank Zimmerman   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Blanche Harmon                                 |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |   | 16b. SOCIAL SECURITY NO.<br>216-24-8535   |   | 17. INFORMANT<br>ADDRESS<br>Trent Never 416 S. Durham St 21231                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>4589<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Hypotension</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>30 minutes<br>1 hour |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Chronic pulmonary disease, severe malnutrition</u>   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/8</u> 19 <u>83</u> to <u>1/17</u> 19 <u>83</u> , that (I) (we) lost<br>saw the deceased alive on <u>1/17</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (If we) (did) (did not) view the body after death.  |   |   |   |  |  |
| 22b. SIGNATURE<br><u>Barbara Little</u>   |   | DEGREE<br>MD  |   | 22c. DATE SIGNED<br>1/17/83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Barbara Little MD  |   | 22e. ADDRESS<br>Dept. of Medicine, Johns Hopkins Hospital   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |   | 23b. DATE<br>Jan 21, 83   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Balto. National Cem Baltimore, Maryland        |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |   | 24. FUNERAL DIRECTOR<br>NAME Dippel Funeral Homes, Inc. ADDRESS 7110 Belair Road<br>Baltimore, Md.  |   |  |  |
| 25a. DATE REC'D. BY REGISTRAR<br>JAN 19 1983  |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |   |  |  |

BP





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PW 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |   |   |  |  |  |  |  |                   | REG. NO. 73 01064                            |  |
|--|--|---|---|--|--|--|--|--|-------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Sidney Jarvis</b>   |  |   |   |  |  |  | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1 20 19 83</b> |  | 2b. HOUR <b>M</b> |  |  |
| 3. SEX <b>male</b>   |  | 4. RACE <b>black</b>                      |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>12 4 17</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>65 YRS.</b>   |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.  |                   | 7c. DATE PRONOUNCED DEAD <b>1 20 19 83</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b> |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                               |  |  |                   |  |  |
| 11. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1703 N. Regester St.</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |                   | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| 13a. STATE <b>Md</b>   |  | 13b. COUNTY                               |   | 13c. CITY OR TOWN <b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>21085 Joppa Md<br/>1706 Manderville Rd</b>                |                   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Willie Jarvis</b>  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Lucy Harris</b>   |  |  |  |  |                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>  |  |   |   | 16b. SOCIAL SECURITY NO. <b>N/A</b>  |  | 17. INFORMANT ADDRESS <b>Joyce Cheshire 1327 N. Fulton Ave</b>                               |  |  |                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>4292</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  |  |   |   |  |  |  |  |  |                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |  |   |   |  |  |  |  |  |                   |  |  |
| 19a. DATE OF OPERATION   |  |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                   |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                |  |  |                   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |                   |  |  |
| 27a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |   |   |  |  |  |  |  |                   |  |  |
| ACTUAL SIGNATURE <b>H R Guard</b>  |  |   |   | TITLE (SPECIFY) <b>Assistant</b> M.D.  |  |  |  | DATE SIGNED <b>1/20/83</b>   |                   |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>   |  |   |   | ADDRESS <b>111 Penn St., Balto., Md.</b>   |  |  |  |  |                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>1/24/83</b>                  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Mt Zion Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Anne Arundel Co Md</b>                         |  |  |                   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS <b>William C. March F/H 1101 E. North Ave</b>   |  |   |   |  |  | 25a. DATE REC'D BY REGISTRAR <b>18N 24 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>                                    |                   |  |  |



TO DIRECTOR

FROM [illegible]



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL EXAMINER. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |   |  | REG. NO. 01065 |  |
|--|--|--|--|--|--|--|--|---|--|----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Emma Evelyn Jenkins</b>   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>1</b> DAY <b>7</b> YEAR <b>1983</b> |  | 2b. HOUR <b>4:30</b>  |  |                |  |
| 3. SEX <b>F</b>  |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>2/7/</b> DAY <b>1896</b> YEAR <b>86</b> YRS.  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b>  |  | 7. IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN. <b>0</b>        |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>   |  |   |  |                |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>11 E. West Street</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>                           |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                |  |
| 13a. STATE <b>Md.</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN <b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  | 13e. STREET ADDRESS <b>11 E. West Street 21230</b>                                  |  |                |  |
| 14. FATHER'S NAME<br>FIRST <b>William</b> MIDDLE <b>Schulte</b> LAST <b>Schulte</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Elizabeth</b> MIDDLE <b>-----</b> LAST <b>-----</b>   |  |  |  |   |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>   |  |  |  | 16b. SOCIAL SECURITY NO. <b>220 46 7562</b>  |  | 17. INFORMANT ADDRESS <b>Md. 21234 John Schutz, 3114 Orlando Ave., Baltimore,</b>                        |  |   |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) <b>-----</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>-----</b><br>DUE TO, OR AS A CONSEQUENCE OF                                   |  |  |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |  |  |  |  |   |  |                |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                            |  |   |  |                |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |                |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |  |  |   |  |                |  |
| ACTUAL SIGNATURE <b>H R Guard</b>  |  |  |  | TITLE (SPECIFY) M.D. <b>Assistant</b> MEDICAL EXAMINER   |  |  |  | DATE SIGNED <b>1/8/83</b>   |  |                |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>   |  |  |  | ADDRESS <b>111 Penn St., Balto., Md.</b>   |  |  |  |   |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (S) <b>Cremation</b>   |  | 23b. DATE <b>1/11/1983</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Westview Mem. Pk.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>                                    |  |   |  |                |  |
| 24. FUNERAL DIRECTOR <b>George J. Gonce, 4001 Ritchie Hg., Baltimore, Md. 21225</b>  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 12 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Gonce</b>                                     |  |                |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 83 01066  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |   |  |
| 1 DECEASED NAME FIRST MIDDLE LAST<br>HORTENSE E. JENKINS   |  |  |  | 1 10 83  |  |   |  |
| 3 SEX<br>Female  |  | 4 RACE<br>Black  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>2 17 22  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>60  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE CITY   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE UNION MEMORIAL HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Benjamin Jenkins   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Viola Noble   |  | 13e. STREET ADDRESS<br>103 E. 23rd St. 21218   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>214-18-3359  |  | 17 INFORMANT ADDRESS<br>Margaret E. Hatchett 103 E. 23rd St.   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>respiratory arrest</u><br>4275<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>2nd previous cardiac arrest CNS hypoxia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>previous cardiac arrest</u><br>Approximate interval between onset and death<br>5 days<br>5 days |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>renal failure with nephrotic syndrome 2° to light chain disease</u>   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (1) this hospital attended the deceased from <u>1/9</u> , 19 <u>83</u> , to <u>1/10</u> , 19 <u>83</u> , that (1) (we) lost saw the deceased alive on <u>1/9</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) we (did) (did not) view the body after death.  |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>D M Ruffley  |  | DEGREE<br>MD   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                 |  | 22c. DATE SIGNED<br>1/10/83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>David M Ruffley   |  | 22e. ADDRESS<br>Union Memorial Hospital Balto Md 21004   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>1/14/83   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave.  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 11 1983   |  | 25b. REGISTRAR'S SIGNATURE<br>Joan J. Conner  |  |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

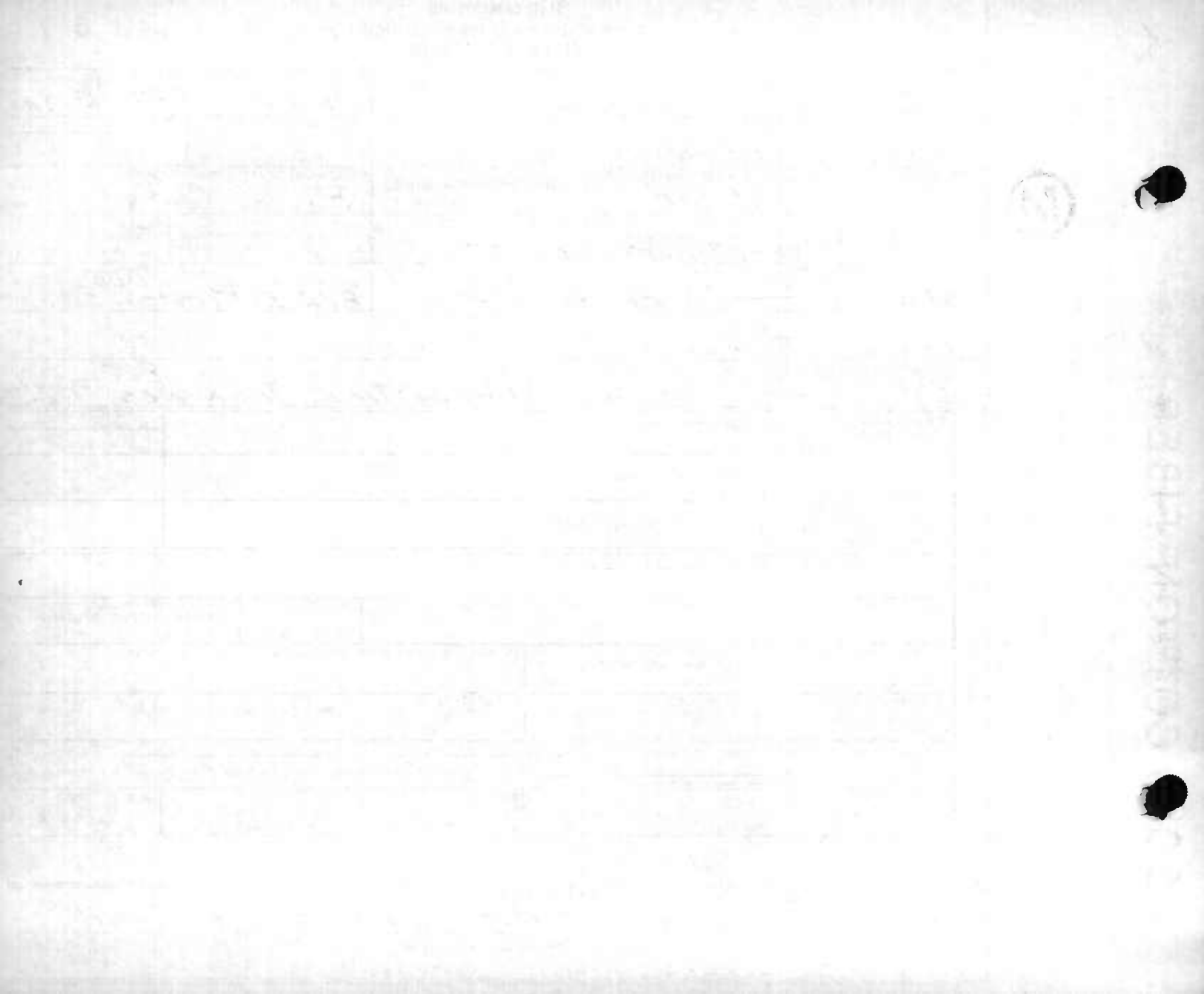
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by this funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |   |   |  |  |
|--|--|--|--|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>EUGENE JENNINGS</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Jan. 23, 1983</b>               |   |  | 2b. HOUR<br><b>@ 1 A.M.</b>   |   |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>NEGROID</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan 26, 1919</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>M.S.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD                                   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto. City</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>822 E. PRESTON ST.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Janitor</b>              |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Industry</b>   |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>—</b>  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>822 E. Preston St.</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>PAUL JENNINGS</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARTHA ?</b>   |  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>                  |   |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>238-26-0733</b>   |  | 17. INFORMANT<br><b>MAUDESTINE JENNINGS</b>  |  |   |  | ADDRESS<br><b>822 E. Preston St.</b>  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1629 IMMEDIATE CAUSE (a) Lung Cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Cerebro</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b> P.M.      |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                              |  |  |  |   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>P Konits MD</b>   |  |  |  |   |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>1/24/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>P Konits MD</b>  |  |  |  |   |  | 22e. ADDRESS<br><b>Lutheran Hosp</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>1-29-83</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>mt. Auburn Cem.</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Calvin B. Scruggs Sr.</b>   |  |  | ADDRESS<br><b>4112 E. Preston St.</b>                                  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>24 1983</b>              |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Smith</b>              |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8301068   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. STATE REGISTRAR   |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Sylvester T. Jennings   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>1 14 83   |  |  |  |
| 3. SEX<br>male   |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>1 17 17  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Johns Hopkins Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland   |  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore   |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  | 13e. STREET ADDRESS<br>2028 Kennedy Ave. 21218  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Charles Jennings  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Angeline LeVere   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>YES   |  |  |  | 16b. SOCIAL SECURITY NO.<br>218-07-9409   |  | 17. INFORMANT ADDRESS<br>James Jenkins 606 Richwood Avenue   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>4100 IMMEDIATE CAUSE (a) Acute MI<br>DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension & ext. cardiovascular disease 14 yrs<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minute |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/14/69, 19____, to 1/14/83, 1983, that (I) (we) lost saw the deceased alive on 12/17/82, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.        |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>MARION FRIEDMAN, MD  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>1/18/83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MARION FRIEDMAN, MD   |  |  |  | 22e. ADDRESS<br>5211 Hartford Rd  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL  |  | 23b. DATE<br>1/18/83   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mount Calvary Cem.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Co. Md.   |  |
| 24. FUNERAL DIRECTOR NAME<br>Wm. C. March F/H Inc. 1101 E. North Avenue  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 18 1983  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. L... ..  |  |

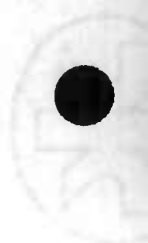
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FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 0 6 9

REG. NO.

|  |  |  |   |   |                              |  |
|--|--|--|---|---|------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SOPHIA FRED A JOHNS</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 25 83</b> |   | 2b. HOUR<br><b>8:15 P.M.</b> |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>white</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 7 1912</b>                                 |                              |  |
| 6. AGE (IN YEARS, LAST BIRTHDAY)<br><b>75 70</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>75 70</b>  |   | 8. IF UNDER 72 HRS.<br>HOURS MIN.<br><b>75 70</b>                                     |                              |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 10. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto City</b> MD                         |                              |  |
| 12. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore General Hosp</b> |   | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>   |                              |  |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>15a. STATE<br><b>MD</b>   |  | 16. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 17. STREET ADDRESS<br><b>744 Jack St., 21230</b>                                      |                              |  |
| 18. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Samuel Harris</b>   |  | 19. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LENA MAGGID</b>  |   | 20. SOCIAL SECURITY NO.<br><b>218 10 7670A</b>  |                              |  |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 22. INFORMANT<br><b>NATHAN HARRIS</b>  |   | 23. ADDRESS<br><b>3837 MENLO DR. BALTO., MD</b>                                       |                              |  |
| 24. CAUSE OF DEATH<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>pulmonary edema</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>4280<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 1/2 hours</b> |  |  |   |   |                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>   |  |  |   |   |                              |  |
| 25a. DATE OF OPERATION   |  | 25b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 26a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>             |                              |  |
| 27a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 27b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)        |                              |  |
| 28a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 28b. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 28c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>3001 S. Hanover St. Balto</b> |                              |  |
| 29. I certify that (I) (this hospital) attended the deceased from <b>1/11</b> , 19 <b>83</b> , to <b>1/25</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1/25</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.                                    |  |  |   |   |                              |  |
| 30. SIGNATURE<br><b>P.H. COOKE</b>   |  | 31. DEGREE<br><b>MD</b>  |   | 32. DATE SIGNED<br><b>1/25/83</b>   |                              |  |
| 33. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>P.H. COOKE</b>  |  | 34. ADDRESS<br><b>3001 S. Hanover St. Balto</b>  |   |   |                              |  |
| 35a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 35b. DATE<br><b>JAN. 26, 1983</b>  |   | 35c. NAME OF CEMETERY OR CREMATORY<br><b>CHIZUK AMUNO</b>                             |                              |  |
| 36a. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>   |  | 36b. ADDRESS<br>ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |   | 37. DATE REC'D. BY REGISTRAR<br><b>FEB 1 1983</b>                                     |                              |  |
| 38. REGISTRAR'S SIGNATURE<br><b>John J. Canfield</b>   |  | 39. REGISTRAR'S SIGNATURE<br><b>John J. Canfield</b>   |   |   |                              |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

(M)

(10)

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM-PM 3. RETAIN PAGES 1 AND 2 WITH YOURS TO FUNERAL DIRECTOR; PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |                  |                  |   |  |  |  |   |                    |                                |  |   |  |  |  |   |  |  |  |
|--|--|------------------|------------------|---|--|--|--|---|--------------------|--------------------------------|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                  | FIRST<br>William |   |  | MIDDLE<br>V.                               |  |   | LAST<br>Johns, Sr. |                                |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br>1 9 19 83                 |  |  |  | 2b. HOUR<br>3:52<br>A M                           |  |  |  |
| 3. SEX<br>M  |  | 4. RACE<br>WHITE |                  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>SEPT. 23 1915   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS. |  | IF UNDER 1 YR.<br>MONTHS DAYS   |                    | IF UNDER 24 HRS.<br>HOURS MIN. |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>1 9 19 83                             |  |  |  | 2d. HOUR<br>A M                                   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.   |  |                  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                    |                                |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                          |  |  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospital |  |  |  |   |                    |                                |  | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)<br>MAINTENANCE         |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Church Hosp. |  |  |  |
| 13a. STATE<br>MD.  |  |                  |                  | 13b. COUNTY<br>BALTO.   |  |  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                    |                                |  | 13d. STREET ADDRESS<br>21224<br>606 S. ELLWOOD AVE.                                 |  |  |  |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JAMES JOHN   |  |                  |                  |   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>HELEN STINCHCOMB   |                    |                                |  |   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>YES   |  |                  |                  | 16b. SOCIAL SECURITY NO.<br>WILL 217-01-7872  |  |  |  | 17. INFORMANT<br>ADDRESS<br>ELCHNORA E. JONES SAME 21224  |                    |                                |  |   |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease<br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                  |                  |   |  |  |  |   |                    |                                |  |   |  |  |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |  |                  |                  |   |  |  |  |   |                    |                                |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |                  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |                    |                                |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |   |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                    |                                |  |   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                    |                                |  |   |  |  |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural Causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |  |                  |                  |   |  |  |  |   |                    |                                |  |   |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE<br>H. Shaid   |  |                  |                  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER  |  |  |  |   |                    |                                |  | DATE SIGNED<br>1/10/83  |  |  |  |   |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Hormez R. Guard, M.D.  |  |                  |                  | ADDRESS<br>111 Penn St., Balto, Md.   |  |  |  |   |                    |                                |  |   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)<br>BURIAL   |  |                  |                  | 23b. DATE<br>1-11-83  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MEADOWRIDGE PARK  |                    |                                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>HOWARDS CO. MD.                       |  |  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>HOFFMANN - SKARDA F.H.   |  |                  |                  |   |  |  |  | ADDRESS<br>3218 HUDSON ST.  |                    |                                |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 11 1983  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Joan G. Carrier     |  |  |  |

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UNITED STATES

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |                         |  |   | 83 01071  |  |
|--|-------------------------|--|---|---|--|
| 1. FOR STATE REGISTRAR   |                         |  |   | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Bernard R Johnson</b>   |                         |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1/16/83</b> |   | 2b. HOUR<br><b>9.45 PM</b>                   |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>BLACK</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>03 15 07</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                                |  |
| 11. CITY OR TOWN OF DEATH<br><b>BALTO</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University of Maryland</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>Baltimore</b>                 | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Johnson</b>   |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lula</b>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>213-03-8650</b>   |   | 17. INFORMANT ADDRESS<br><b>Mildred V. Johnson 2814 Auchentoroly Ter.</b>                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1850 IMMEDIATE CAUSE (a) Aspiration Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Prostate CA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |                         |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Cachexia</b>  |                         |  |   |   |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/14</b> 19 <b>83</b> to <b>1/16</b> 19 <b>83</b> that (I) (we) lost saw the deceased alive on <b>1/16</b> 19 <b>83</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                   |                         |  |   |   |  |
| 22b. SIGNATURE<br><b>George Graham</b>   |                         |  |   | 22c. DATE SIGNED<br><b>1/16/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GROLEAN</b>  |                         |  |   | 22e. ADDRESS<br><b>225 Greene Street</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |                         | 23b. DATE<br><b>1/21/83</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Veteran Cem.</b>                                   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crownsville Md.</b>   |                         | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 18 1983</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H Inc 1101 E North Avenue</b>  |                         |  |   |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the time of burial, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health officer's office with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |                         |  |  |   |                              |
|--|-------------------------|--|--|---|------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Elsie Johnson</b>   |                         |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 26, 1983</b> |   | 2b. HOUR<br><b>3:30 P.M.</b> |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 1 16</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.   |                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S. Carolina</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                              |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |                         | 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b>               |                              |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |                         | 12b. KIND OF BUSINESS OR INDUSTRY  |  | 13a. STREET ADDRESS<br><b>1627 W. Lafayette Ave. 2nd Fl.</b>  |                              |
| 13b. STATE<br><b>Maryland</b>  |                         | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>N/A</b>   |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>N/A</b>  |  |   |                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>156-12-1886</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>James E. Johnson 1627 W. Lafayette Ave. 2nd Fl.</b>  |                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1629</b> IMMEDIATE CAUSE (a) <b>Hypercalcemia, Uremia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Carcinoma of the lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                         |  |  |   |                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Possible onset of pneumonia today</b>  |                         |  |  |   |                              |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                              |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                         | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  |   |                              |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                              |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>January 12, 19 83</b> , to <b>January 26, 19 83</b> , that (X) (we) lost saw the deceased alive on <b>January 26, 19 83</b> , and that in (m) (our) opinion death occurred on the date and hour and from the causes stated above. (A) (we) (did) (did not) view the body after death.  |                         |  |  |   |                              |
| 22b. SIGNATURE<br><i>Harry M. Harris</i>   |                         | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>1/26/83</b>  |                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Harry M. Harris, M.D.</b>  |                         | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>   |  |   |                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |                         | 23b. DATE<br><b>2/1/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cem.</b>   |                              |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. Md.</b>   |                         | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H Inc. 1101 E. North Avenue</b>  |  |   |                              |
| 25a. DATE REC'D. BY REGISTRAR  |                         | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Conner</i>  |  |   |                              |



Department of the Army  
Washington, D. C.

Respectfully,  
Very truly yours,

John F. Kennedy  
President of the United States

JAN 28 1963  
John F. Kennedy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |   |  | REG. NO.   |  |
|--|--|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  |  |  | 2a. DATE OF DEATH   |  | 2b. HOUR   |  |
|  |  | EThelene JOHNSON   |  |  |  |  |  | 1-20-83   |  | 1:40 AM  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. IF UNDER 1 YEAR  |  | 8. IF UNDER 24 HRS   |  |
| Female   |  | Black  |  | 8 24 24  |  | 57   |  | MONTHS  |  | DAYS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |  |  |
| NOLAN NC   |  | USA  |  |  |  | BALTIMORE CITY MD  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Baltimore  |  | Bon Secours  |  |  |  |  |  | Homemaker   |  | at home  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS   |  |  |  |
| MD   |  |  |  | BALTIMORE  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 231 N MONROE ST   |  | 21223  |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |  |  |
| JOHN HENRY DANIELS   |  |  |  | NEAL Mc DANIEL   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |  |  |
| NO   |  |  |  | 213-30-0877  |  | Ethel BARKAVILLE   |  | 1022 N. GILMAN  |  | 21217  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |   |  |  |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |   |  |  |  |
| 5715 IMMEDIATE CAUSE (a) Inevitable severe stroke  |  |  |  |  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Acute fibrinous Peritonitis - Hours   |  |  |  |  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) Chronic - severe liver cirrhosis - Years  |  |  |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Erosive Duodenitis   |  |  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |  |
|  |  |  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION  |  |   |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  |  |  | STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 1/20/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  | 1/17/83  |  | 1/20/83  |  |   |  |  |  |
| 22b. SIGNATURE   |  |  |  | DEGREE   |  |  |  | 22c. DATE SIGNED  |  |  |  |
| Dr. [Signature]  |  |  |  | MD   |  |  |  | 1/20/83   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |  |  |   |  |  |  |
| Vance L. F. ALBUQUERQUE  |  |  |  | 1948 Bell St Baltimore MD  |  |  |  | 21223   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |  |  |
| Burial   |  |  |  | 1/24/83  |  | Mt Airy  |  | Baltimore   |  | MD   |  |
| 24. FUNERAL DIRECTOR   |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| Mr. [Signature]  |  |  |  | JAN 21 1983  |  |  |  | John J. Conner  |  |  |  |

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FILED. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |         |                                    |  |                                  |                                   |   |  |  |   |   |  |
|--|---------|------------------------------------|--|----------------------------------|-----------------------------------|---|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         |                                    | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED  |                                  |                                   | MONTH DAY YEAR  |  |  | 2b. HOUR  |   |  |
| George Edward Johnson Jr.  |         |                                    | 1  |                                  |                                   | 19  |  |  | 19 83   |   |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH<br>MONTH DAY YEAR | 6. AGE (IN YEARS<br>LAST BIRTHDAY)   | 7. IF UNDER 1 YR.<br>MONTHS DAYS | 8. IF UNDER 24 HRS.<br>HOURS MIN. | 2c. DATE<br>PRONOUNCED<br>DEAD  |  |  | 2d. HOUR  |   |  |
| M  | Black   | 7 6 42                             | 40 YRS.  |                                  |                                   | 1 19 19 83  |  |  | 3:30 P M  |   |  |
| 7b. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |         |                                    | 7c. CITIZEN OF WHAT COUNTRY?   |                                  |                                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |   |  |
| Maryland   |         |                                    | USA  |                                  |                                   |   |  |  | Baltimore City MD.  |   |  |
| 10. CITY OR TOWN OF DEATH  |         |                                    | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                  |                                   | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |   |  |
| Baltimore  |         |                                    | 1 S. Fulton Ave.   |                                  |                                   |   |  |  |   |   |  |
| 13a. STATE   |         |                                    | 13b. COUNTY  |                                  |                                   | 13c. CITY OR TOWN   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| Md   |         |                                    | Balto.   |                                  |                                   | 1 South Fulton Ave  |  |  | 21223   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |         |                                    |  |                                  |                                   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |  |   |   |  |
| George Edward Johnson Sr.  |         |                                    |  |                                  |                                   | Mary Artis  |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |         |                                    | 16b. SOCIAL SECURITY NO.   |                                  |                                   | 17. INFORMANT   |  |  | ADDRESS   |   |  |
| Yes  |         |                                    | 215 40 8237  |                                  |                                   | George Johnson  |  |  | 422 Mt. Holley St.  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>4512 IMMEDIATE CAUSE (a) Pulmonary embolism from leg vein thromboses<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |         |                                    |  |                                  |                                   |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |         |                                    |  |                                  |                                   |   |  |  |   |   |  |
| 19a. DATE OF OPERATION   |         |                                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                                  |                                   |   |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |                                    | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                                  |                                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |         |                                    | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |                                  |                                   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                                    |  |                                  |                                   |   |  |  |   |   |  |
| ACTUAL<br>SIGNATURE  |         |                                    | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER   |                                  |                                   |   |  |  | DATE<br>SIGNED 1/20/83  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |         |                                    | ADDRESS  |                                  |                                   |   |  |  |   |   |  |
| Hormez R. Guard, M.D.  |         |                                    | 111 Penn St., Balto., Md.  |                                  |                                   |   |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |         |                                    | 23b. DATE  |                                  |                                   | 23c. NAME OF CEMETERY OR CREMATORY  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |   |  |
| Burial   |         |                                    | 1-24-83  |                                  |                                   | Crownsville VA Cem.   |  |  | Crownsville Md.   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |         |                                    |  |                                  |                                   | 25. REGISTRAR'S SIGNATURE   |  |  |   |   |  |
| Brown/Thompson F.H. 1913 W. Balto. St.   |         |                                    |  |                                  |                                   | JAN 21 1983   |  |  | John J. Guard   |   |  |



RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE

14

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE

*Handwritten signature*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 01075

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |  |  |   |  |  |   |  |  |  |  |  |
|--|--|--|---|--|--|---|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>AKA<sup>ST</sup> GERTRUDE C</b>   |  |  | MIDDLE <b>C</b>   |  |  | LAST <b>JOHNSON</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Jan 31 83</b>   |  |  | 2b. HOUR<br><b>2:05 PM</b>   |  |  |
| 3. SEX<br><b>FEMALE</b>  |  |  | 4. RACE<br><b>Cauc WHITE</b>  |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 23 93</b>  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>89</b> YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore Gen. Hospital</b> |  |  |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Packer</b>               |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Chemical Co.</b>   |  |  |
| 13a. STATE<br><b>Md.</b>   |  |  | 13b. COUNTY   |  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS<br><b>5 Talbot Street 21225</b>  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Wesley</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Ellen Hardesty</b>   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>218 18 6405</b>  |  |  | 17. INFORMANT<br>ADDRESS<br><b>Alamo, Tx 78516</b><br><b>Gertrude Oldham 1341 W. Bus 83</b>                                |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>5119</b> IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ASCVD</b> |  |  |   |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Ventricular aneurysm, prob pneumonia, renal failure</b>   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>pleural effusion</b>   |  |  |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 17</b> , 19 <b>83</b> , to <b>Jan 31</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>Jan 31</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                 |  |  |   |  |  |   |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Maureen L. Durkin</b>   |  |  |   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |  |   |  |  | 22c. DATE SIGNED<br><b>1/31/83</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MAUREEN L. DURKIN</b>  |  |  |   |  |  | 22e. ADDRESS<br><b>3001 S. Hanover St<br/>3001 S But Gen Hosp Baltimore Md 21230</b>  |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>2/3/83</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery Baltimore, Md.</b>   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>21225</b>                                      |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>George J. Gonce 4001 Ritchie Hwy</b>  |  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 4 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Sam J. Connel</b> |   |  |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



## MEDICAL CERTIFICATION



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Handwritten text, possibly a signature or date, appearing upside down.

Handwritten text, possibly a signature or date, appearing upside down.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 83 01077  |  |  |  |
|--|--|--|--|---|--|--|--|
| 1 - STATE REGISTRAR  |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Terley Johnson</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 29 83</b>   |  | 2b. HOUR<br><b>4 45 PM</b>   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 04 1913</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>TN</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore General Hosp</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>xxxxxx Ret. Secretary</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>  |  | 13b. CITY OR TOWN<br><b>Anne Arundel Pasadena</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13d. STREET ADDRESS<br><b>21122 8263 Spring Knoll Drive</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry JONES</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LOA PENNINGTON</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no xxxxx</b>   |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>220 24 1313</b>   |  | 17. INFORMANT<br><b>WILMA PARSONS - Same address</b>   |  |   |  | ADDRESS  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiopulmonary failure</b><br><b>4860</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>pneumonitis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>seizures</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>9 days</b> |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>meningioma</b>   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/20/83</b> to <b>1/29/83</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/29/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Peter H Cooke</b>   |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>1/29/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Peter H Cooke</b>  |  | 22e. ADDRESS<br><b>3001 S. Hanover St. Balto</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/2/1983</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, A. A. Co., Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>McCurly Funeral Homes</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 2 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John G. Gurnea</b>  |  |



100% COPIES

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FEB 2 1977  
FEB 2 1977



BP

DHMH - 16 50M / 1  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  | 8 3 0 1 0 7 8 |  |
|--|--|--|--|--|---------------|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  | REG. NO.      |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LETHIA JOHNSON</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1-27-83</b>   |               |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>BLACK.</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>2 23 11</b>  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  | 8. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS   |               |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LUTHERAN HOSPITAL</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> MD.                                 |               |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |               |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>  |  |  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |               |  |
| 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |               |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Sandy Alexander Johnson</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Carrie Mason</b>                            |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>22-345-7204</b>   |               |  |
| 17. INFORMANT ADDRESS<br><b>Julia Lawrence</b>   |  |  |  |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>7070</b> IMMEDIATE CAUSE (a) <b>Septis</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Infected Decubitus</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>CVA.</b>   |  |  |  |  |               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):   |  |  |  |  |               |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |               |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>9/13 1982</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                |               |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/13</b> , 19 <b>82</b> , to <b>1/27</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>1/27</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |               |  |
| 22b. SIGNATURE<br><b>BICH T. DUONG</b>   |  | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>1/27/83</b>   |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BICH T. DUONG</b>  |  | 22e. ADDRESS   |  |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>B</b>  |  | 23b. DATE<br><b>2/2/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Catholics me pt</b>                                 |               |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Barto md</b>   |  |  |  |  |               |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Joseph L. Rums</b>   |  | ADDRESS<br><b>2222 W York ave</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 2 1983</b>   |               |  |
|  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Lawrence</b>  |  |  |               |  |



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   | 8 3 0 1 0 7 9  |                      |  |  |
|---|--|---|---|--|----------------------|--|--|
| 1. FOR STATE REGISTRAR  |  |   |   | REG. NO.   |                      |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Maude E. Johnson  |  |   | 2a DATE OF DEATH MONTH DAY YEAR<br>January 8 1983 |  | 2b HOUR<br>4:10 P.M. |  |  |
| 3 SEX<br>Female   |  | 4 RACE<br>Negro   |   | 5 DATE OF BIRTH MONTH DAY YEAR<br>Feb 24 1897  |                      | 6 AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                      | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2527 Oakley Ave. |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |                      | 12b KIND OF BUSINESS OR INDUSTRY   |  |
| 13a STATE<br>Maryland   |  | 13b COUNTY<br>Baltimore   |   | 13c INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                      | 13d STREET ADDRESS<br>2527 Oakley Avenue 21215   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Joseph Wilmore  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Ruth Curtis  |   |  |                      |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-07-0846   |   | 17 INFORMANT ADDRESS<br>Edna Williamson/2527 Oakley Avenue 21215   |                      |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>1629 IMMEDIATE CAUSE (a) Respiratory arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) Bleeding into the lungs<br>DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of lung.<br>2 months<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |  |                      |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |  |                      |  |  |
| 19a DATE OF OPERATION<br>—  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                      |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                      |  |  |
| 22a. I certify that (I) (myself) attended the deceased from December 19 82 to Jan 8 1983, that (I) (we) saw the deceased alive on Dec 31 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                  |  |   |   |  |                      |  |  |
| 22b. SIGNATURE<br>O. O. (signature)   |  | DEGREE<br>M.D.  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |                      | 22c. DATE SIGNED<br>1/10/83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>OLUSEGUN O. LAWOYIN  |  | 22e. ADDRESS<br>200 W. OLD SPRING LANE, Baltimore, MD 21210.  |   |  |                      |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>01/14/83   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>ARBUTUS MEM PARK   |                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE BALTO Md.  |  |
| 24 FUNERAL DIRECTOR NAME<br>Marshall W. Jones   |  | 24b. ADDRESS<br>4101 EDMONDSON AVE 21229  |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 17 1983   |                      | 25b. REGISTRAR'S SIGNATURE<br>John J. Conner   |  |

14

29th Nov 1953  
Sundown at 17.45  
Clear, cold, dry

29th Nov 1953



RECEIVED  
U.S. DEPARTMENT OF THE ARMY  
WASHINGTON, D.C. 20315



FILED

U.S. DEPARTMENT OF THE ARMY

NOV 11 1964



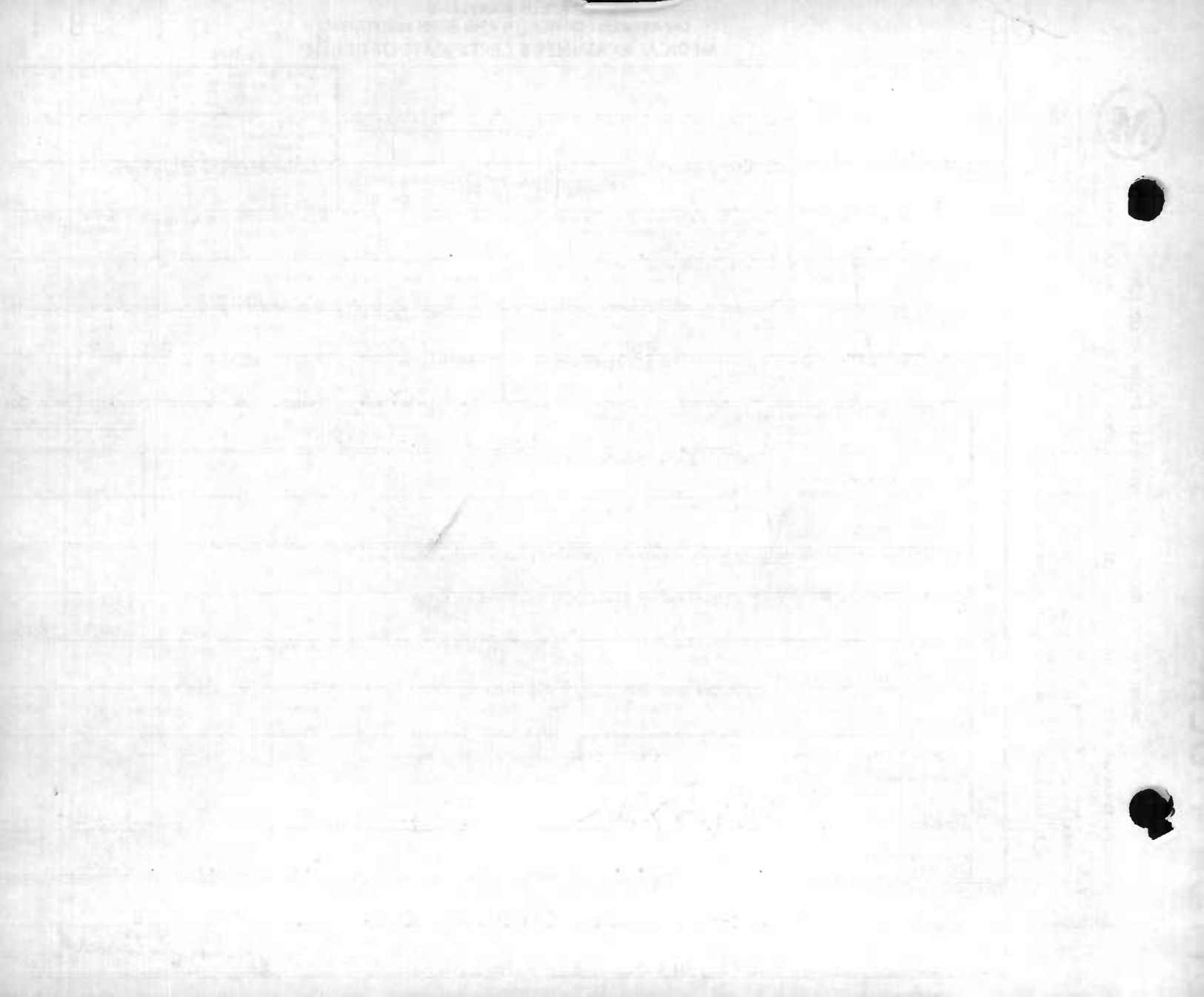
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                        |   |   |  |   |   |   |  | REG. NO. 83 01081   |  |
|---|--|------------------------|---|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>VERNICE I. JOHNSON</b>   |  |                        |   |   |  |   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MATED <input type="checkbox"/> MONTH DAY YEAR <b>1 17 19 83</b> |   | 2b. HOUR <b>5:46</b>   |   |  |
| 3. SEX <b>FEMALE</b>  |  | 4. RACE <b>BLACK</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>1-05-09</b>           |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>74</b> YRS.   |   | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>1 17 19 83</b>    |  | 2d. HOUR <b>5:46</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VA</b>   |  |                        | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD. |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  |                        | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>auto - 631 N. Woodington Ave.</b> |   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                        |   |   |  |   |   |   |  |   |  |
| 13a. STATE <b>MD</b>  |  | 13b. COUNTY <b>---</b> |   | 13c. CITY OR TOWN <b>BALTO</b>                              |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS <b>631 WOODINGTON RD. 21229</b>             |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>CLEVELAND COLEMAN</b>   |  |                        |   |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>NANNIE BURNETT</b>   |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>NO</b>   |  |                        |   | 16b. SOCIAL SECURITY NO. <b>---</b>                         |  | 17. INFORMANT ADDRESS <b>HENRIETTA BAILEY 631 WOODINGTON RD</b>   |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4029</b> IMMEDIATE CAUSE (a) <b>Hypertensive arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |                        |   |   |  |   |   |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.   |  |                        |   |   |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  |                        |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |   |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                        |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                        |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . |  |                        |   |   |  |   |   |   |  |   |  |
| ACTUAL SIGNATURE <b>Ann M. Dixon</b>  |  |                        |   | TITLE (SPECIFY) <b>M.D. Assistant</b>                       |  |   |   | DATE SIGNED <b>1-20-83</b>                                      |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>   |  |                        |   | ADDRESS <b>111 Penn St., Balto., Md. 21201</b>              |  |   |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  |                        |   | 23b. DATE <b>1-22-83</b>                                    |  | 23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL CEM.</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>BALTIMORE, MD</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>VERNON R. BAILEY</b>  |  |                        |   | ADDRESS <b>1348 N. CALHOUN ST</b>                           |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 21 1983</b>  |   | 25b. REGISTRAR'S SIGNATURE <b>John J. Gower</b>                 |  |   |  |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                         |  |  |   |   |  |  |   |  | REG. NO.                                     |  |
|---|-------------------------|--|--|---|---|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Wilbert Johnson</b>  |                         |  |  |   |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br><b>1 4 1983</b>  |  | 2b. HOUR<br>M<br><b>5:37</b>  |  |  |  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>NEGRO</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9-15-45</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>38 YRS.</b> | IF UNDER 1 YR.<br>MONTHS DAYS<br><b>17</b>  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>17</b> | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>1 4 1983</b>  |  | 7d. HOUR<br>M<br><b>5:37</b>  |  |  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE<br><b>MD.</b>  |                         |  |  | 13b. COUNTY<br><b>DORCHESTER</b>  |   | 13c. CITY OR TOWN<br><b>Cambridge</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 13e. STREET ADDRESS<br><b>810 ALLEN ST.</b>   |                         |  |  | 13f. CITY OR TOWN<br><b>Cambridge</b>   |   | 13g. STATE<br><b>MD.</b>   |  | 13h. ZIP CODE<br><b>21613</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JAMES H. JOHNSON</b>   |                         |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CATHERINE COOPER</b>  |   |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |                         |  |  | 16b. SOCIAL SECURITY NO.<br><b>218-40-6243</b>  |   | 17. INFORMANT<br>(NAME AND ADDRESS)<br><b>CONSTANCE JOHNSON Cambridge, Md.</b>                                       |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: <b>Gunshot wound of head</b><br><b>9554</b> IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: _____<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____ |                         |  |  |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION  |                         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         |  |  | 21b. TIME OF INJURY<br>HOUR MONTH DAY YEAR<br><b>3:30 P.M. 1 4 1983</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br><b>self inflicted gunshot wound</b> |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                         |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>home</b>  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>810 Allen St., Cambridge, Md.</b>                            |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |                         |  |  |   |   |  |  |   |  |  |  |
| ACTUAL SIGNATURE<br><b>Naupie McNeill</b>   |                         |  |  | TITLE (SPECIFY)<br><b>Assistant</b>   |   |  |  | DATE SIGNED<br><b>1/5/83</b>  |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>  |                         |  |  | ADDRESS<br><b>111 Penn St., Balto, Md.</b>  |   |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |                         | 23b. DATE<br><b>1-7-83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bethel A.M.E.</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cambridge DORC MD</b>   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>L.H. BOARDLEY Cambridge, Md. 21613</b>   |                         |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>1 JAN 5 1983</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>  |  |   |  |  |  |

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

PLANT INDUSTRY  
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WASHINGTON, D. C.

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BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the deceased has been placed in the casket, this certificate should be detached for use as the burial-transit permit. Then please remove carbon copiers, and file this permit with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 3B showing any injury, or other traumatic event, the medical examiner must be notified in person.

DHM-16 50M 1/81  
(VRA 15, 4)

Shipped to Van Orsdel Funeral Home, N. Miami Beach, Florida

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |   |   |  |   |  | 8 3 0 1 0 8 3                 |  |
|--|--|---|--|---|---|---|--|---|--|-------------------------------|--|
| FOR<br>1- STATE<br>REGISTRAR   |  |   |  |   |   |   |  |   |  | REG. NO.                      |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>HENRY L. JOHNSTON   |  |   |  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JANUARY 28, 1983   |  |   | 2b. HOUR<br>5:45A <sup>M</sup>                   |                               |  |
| 3 SEX<br>Male  |  | 4 RACE<br>Caucasian   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 14- 1909  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>W. Va.   |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD  |  |   |  |                               |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |  |   |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>retired                      |  |   | 12b KIND OF BUSINESS OR INDUSTRY<br>Steel        |                               |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Md. 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore  |  |   |  |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   | 13e. STREET ADDRESS<br>309 S. Conkling St. 21224 |                               |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joans W. Johnston   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Starkey   |   |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) no   |  |                               |  |
| 16b. SOCIAL SECURITY NO.<br>278-07-4731  |  |   |  | 17. INFORMANT<br>Mrs. Lovina Dice, 309 S. Conkling St.  |   |   |  | ADDRESS 21224   |  |                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>4241 IMMEDIATE CAUSE (a) CARDIAC ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Sepsis<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) PNEUMONIA<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 min<br>4 days<br>7 days |  |   |  |   |   |   |  |   |  |                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>S/P Aortic Valve Replacement CAB, TRACHEOSTOMY   |  |   |  |   |   |   |  |   |  |                               |  |
| 19a. DATE OF OPERATION<br>12/8, 12/9, 12/29  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Aortic Stenosis    |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |   |  |                               |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/8, 1983, to 1/28, 1983, that (I) (we) last saw the deceased alive on 1/28, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.  |  |   |  |   |   |   |  |   |  |                               |  |
| 22b. SIGNATURE<br>E Ruas MD  |  |   |  |   |   | DEGREE  |  |   | 22c. DATE SIGNED<br>1/28/83                      |                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RUAS  |  |   |  |   |   | 22e. ADDRESS<br>JOHNS HOPKINS HOSPITAL  |  |   |  |                               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Removal-Entomb.  |  |   | 23b. DATE<br>1/31/83   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Southern Mem. Pk. |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>N. Miami Beach, Florida   |  |                               |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Zannino Funeral Home, 263 S. Conkling Street   |  |   |  |   |   | 25a. DATE RECD. BY REGISTRAR<br>JAN 28 1983   |  |   | 25b. REGISTRAR'S SIGNATURE<br>John J. Canine     |                               |  |





RECEIVED  
FEB 10 1960

V

39

John G. Smith

FEB 8 1960



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

DHMH-16 50M 1/BI  
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |   |  |  |   |   |   |  |
|---|--|--|--|---|---|--|--|---|---|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   | 8 3 0 1 0 8 5   |  |  |   |   |   |  |
| CERTIFICATE OF DEATH  |  |  |  |   | REG. NO.  |  |  |   |   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CLARENCE JONES</b>   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1/18/83</b>                 |  |  |   |   | 2b. HOUR<br><b>3:00 A.M.</b>  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4/10/01</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b>                                       |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS</b> |   | 8. IF UNDER 24 HRS<br>HOURS MIN.<br><b>YRS</b>                            |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTO. Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>                  |  |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Midtown Home</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY               |   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>  |  |  |  |   | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Balto.</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Jones</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Carrie Poles</b>  |  |  |   |   | 13e. STREET ADDRESS<br><b>2502 N. Ellamont St. 21216</b>                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  |  |  |   | 16b. SOCIAL SECURITY NO.<br><b>219-54-3608T</b>                       |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Alice Johnson 1706 McKean Ave</b>          |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY FAILURE</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASCVD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |   |  |  |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>SP CVA / CBS</b>   |  |  |  |   |   |  |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  |  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |   |   |  |  |   |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  |  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8-185</b> 19 <b>83</b> , to <b>1-18</b> 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>1-18</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |  |  |   |   |   |  |
| 22b. SIGNATURE<br><b>Alejandro C. Enrique</b>   |  |  |  |   | DEGREE<br><b>MD</b>   |  |  |   |   | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ALEJANDRO C. ENRIQUE</b>  |  |  |  |   | 22e. ADDRESS<br><b>2435 W. BELVEDERE 21215</b>                        |  |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>B</b>   |  |  |  |   | 23b. DATE<br><b>1/22/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn</b>                        |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto Md</b>                                   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Joseph C. Russ</b>   |  |  |  |   | ADDRESS<br><b>2222 W. North Ave</b>                                   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>21 1983</b>                                |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. C. Connelley</b>  |   |  |

MEDICAL CERTIFICATION



CLARENCE

JONES

1-1-12

1-1-12

Baltimore City

U.S.A.

Western Union

Baltimore

2001 R. Baltimore, Md.

X

Baltimore

Baltimore

214-38-1000

332/417 42



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the attending physician.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 3 0 1 0 8 6  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1 - FOR<br>STATE<br>REGISTRAR   |  |   |  | REG. NO. 25-46-2613841   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>EDWARD Jones</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-2-83</b>   |  | 2b. HOUR<br><b>1022M</b>   |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>Black (negro)</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 24 16</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Va.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                               |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto. MD.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Md.</b>  |  |   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Balto.</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>? ? ?</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Alice Jennings</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br><b>212-12-9207</b>  |  | 17. INFORMANT<br>ADDRESS <b>840 Maltby Ave. Norfolk, Va.</b>   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Smoke Inhalation</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cerebral Arrest</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>Myocardial Infarction</b> |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>28 days</b><br><b>10 min</b><br><b>10 min</b>                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>—</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>None</b>   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>Smoke - House fire</b>  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>E Mangione</b>   |  |   |  | DEGREE<br>CERTIFICATION APPROVED BY MEDICAL STAFF<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1-2-82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MANGIANTE</b>   |  |   |  | 22e. ADDRESS<br><b>22 So Green St.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/6/83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Zion Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Landsdowns AA Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Chas. A. Rice FSPA 1300 Eutaw Pl,</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 11 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Smith</b>   |  |



... (1993)

251154

STC-15-2507 Justice Center

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 0 8 7

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |   |
|--|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JAMES H JONES</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 25 83</b>                             |  | 2b. HOUR<br><b>1:48 AM</b>  |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>B</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11- 10- 06</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.                              |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VA.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO, CITY</b> MD.                 |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UTHERAN HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Tailor</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>   |
| 13a. STATE<br><b>Md</b>  |  |   | 13b. COUNTY<br><b>Balto</b>   | 13c. CITY OR TOWN<br><b>Balto</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Archie Jones</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Olivia Mitchell</b>           |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>?</b>  | 17. INFORMANT ADDRESS<br><b>Joshua Jones 2035 LANVALE ST</b>                      |  |   |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SEPSIS</b><br><b>7302</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>OSTEOMYELITIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <b>ACUTE RENAL FAILURE</b> |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>STATUS EPILEPTICUS</b>   |  |   |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (this hospital) attended the deceased from <b>1/25</b> 19 <b>83</b> , to <b>1/25</b> 19 <b>83</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/25</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did (did not) view the body after death. |  |   |   |  |   |
| 22b. SIGNATURE<br><b>Raymond H. Flores</b>   |  |   |   | 22c. DATE SIGNED<br><b>1/25/83</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RAYMOND H. FLORES</b>  |  |   |   | 22e. ADDRESS<br><b>Utheran Hospital</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>1/29/83</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn CH.</b>                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto, Md</b>                                  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>VERNON R. Bailey 1348 N. Calhoun St. 21217</b>  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 26 1983</b>                               |  | 25b. REGISTRAR'S SIGNATURE<br><b>Joan J. Conner</b>   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified above.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. The funeral director should file this certificate with the State Dept. of Health and Mental Hygiene. If the death was due to a natural cause, the funeral director should file this certificate with the State Dept. of Health and Mental Hygiene. If the death was due to an injury, or other traumatic cause, the funeral director should file this certificate with the State Dept. of Health and Mental Hygiene. If the death was due to a natural cause, the funeral director should file this certificate with the State Dept. of Health and Mental Hygiene. If the death was due to an injury, or other traumatic cause, the funeral director should file this certificate with the State Dept. of Health and Mental Hygiene.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 3 0 1 0 8 8   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH   |  |  |  |
| FIRST MIDDLE LAST<br>JOHN CALVIN JONES   |  |  |  | MONTH DAY YEAR<br>01/23/83  |  |  |  |
| 3. SEX<br>Male   |  |  |  | 2b. HOUR<br>8:55 PM   |  |  |  |
| 4. RACE<br>Black   |  |  |  | 5. DATE OF BIRTH  |  |  |  |
|  |  |  |  | MONTH DAY YEAR<br>1 17 12   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>GA  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71   |  |  |  |
| 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD   |  |  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL  |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |   |  |  |  |
| 13a. STREET ADDRESS<br>922 Caroline St.  |  |  |  | 13b. CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Belvin Jones   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mattie   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  |  |  | 16b. SOCIAL SECURITY NO.<br>245-03-5651   |  |  |  |
| 17. INFORMANT<br>ADDRESS<br>William Wilson 6641 Knottwood Ct.  |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4149 IMMEDIATE CAUSE (a) hypotension<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ischemic heart disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>renal failure  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |  |  |
| 22a. I certify that (1) this hospital attended the deceased from 12/10/82, to 1/23/83, that (1) (v) lost<br>saw the deceased alive on 1/23/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (1) (v) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>R. GARVER  |  |  |  | 22c. DATE SIGNED<br>1/23/83   |  |  |  |
| 22d. ADDRESS<br>JOHNS HOPKINS HOSP<br>DEPT. OF MED   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  |  | 23b. DATE<br>1/28/83  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Md. Veteran Cem.   |  |  |  | 23d. LOCATION<br>Crownsville COUNTY MD  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave.  |  |  |  | 25a. DATE RECEIVED BY REGISTRAR<br>JAN 27 1983  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br>John J. Carver   |  |  |  |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 3 0 1 0 8 9  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | CERTIFICATE OF DEATH   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH  |  |  |  |
| FIRST MIDDLE LAST  |  |  |  | MONTH DAY YEAR HOUR  |  |  |  |
| Mary L. Jones  |  |  |  | 01 26 - 83 12:28 PM  |  |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  |
| F  |  | B  |  | MONTH DAY YEAR   |  | 68 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| S. Carolina  |  | USA  |  |  |  | City MD.   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| BACTO.   |  | University of Maryland   |  |  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. CITY OR TOWN  |  | 13c. INSIDE CITY LIMITS?   |  | 13d. STREET ADDRESS  |  |
| Maryland   |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 21213 1300 E. Lanvale St. 1st. 501                             |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.                                       |  |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST  |  | NO   |  | 213-62-0512  |  |
| Willie   |  | Stulex   |  | 17. INFORMANT  |  | ADDRESS  |  |
|  |  | Rosa   |  | Lucille Jayroe   |  | 2867 Edgecomb Circle South                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4241 Left Ventricular Failure  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Aortic Insufficiency  |  |  |  |  |  |  | 40 hrs.                                      |
| (c) Aortic Valve Replacement   |  |  |  |  |  |  | 40 hrs.                                      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
| 01-24-83   |  | Aortic Insufficiency   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
|  |  | P.M. 19  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
|  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12 Jan. 1983 to 26 Jan. 1983, that (I) (we) lost saw the deceased alive on 26 Jan. 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| Stephen Lincoln M.D.   |  |  |  |  |  | 01-26-83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |  |  |
|  |  |  |  | 22 So. Greene St. Balto. Md.   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (STATE)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  |
| BURIAL   |  | 1/29/83  |  | Liberty Hill AMECH   |  | Summerton, S.C.  |  |
| 24. FUNERAL DIRECTOR   |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |  |  |
| Wm. C. March F/H Inc. 1101 E. North Ave.   |  |  |  | JAN 27 1983  |  |  |  |
| NAME   |  |  |  | REGISTRAR'S SIGNATURE  |  |  |  |
|  |  |  |  | John J. Connel   |  |  |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the hospital after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  | REG. NO. 83 01090  |  |  |   |  |
|--|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  |  |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>PATRICE JONES</b>   |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>01/10/83</b>  |  |  | 2b. HOUR<br><b>6:35pM</b>   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>9 20 81</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS<br><b>15</b>   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                            |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>211 Beale Court 21231</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Henry Jones</b>  |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Patricia Foster</b>   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>N/A</b>  |  | 17. INFORMANT ADDRESS<br><b>Patricia Foster 211 Beale Ct.</b>  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR ACCIDENT</b><br><b>4240</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>CEREBRAL EDEMA</b><br>(c) <b>CARDIOPULMONARY ARREST</b>        |  |   |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>OPEN HEART SURGERY</b>  |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>1/3/83, x2</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>MITRAL REGURGITATION</b>   |  |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/10/83</b> , 19 <b>83</b> , to <b>1/10/83</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>1/10/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>Timothy Hall</b> DEGREE  |  |   |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED<br><b>1/10/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>TIMOTHY HALL</b>   |  |   |  |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>1/15/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. Md.</b>                          |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Wm. C. March F/h</b>   |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR 15 REGISTRAR'S SIGNATURE<br><b>JAN 13 1983</b>   |  |  |   |  |
| ADDRESS<br><b>1101 E. North Avenue</b>   |  |   |  |  |  |  |  |   |  |

TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK  
SUBJECT: [Illegible]  
[Illegible text follows, appearing to be a memorandum or report with multiple lines of text, some of which are crossed out or heavily faded.]



OCT 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

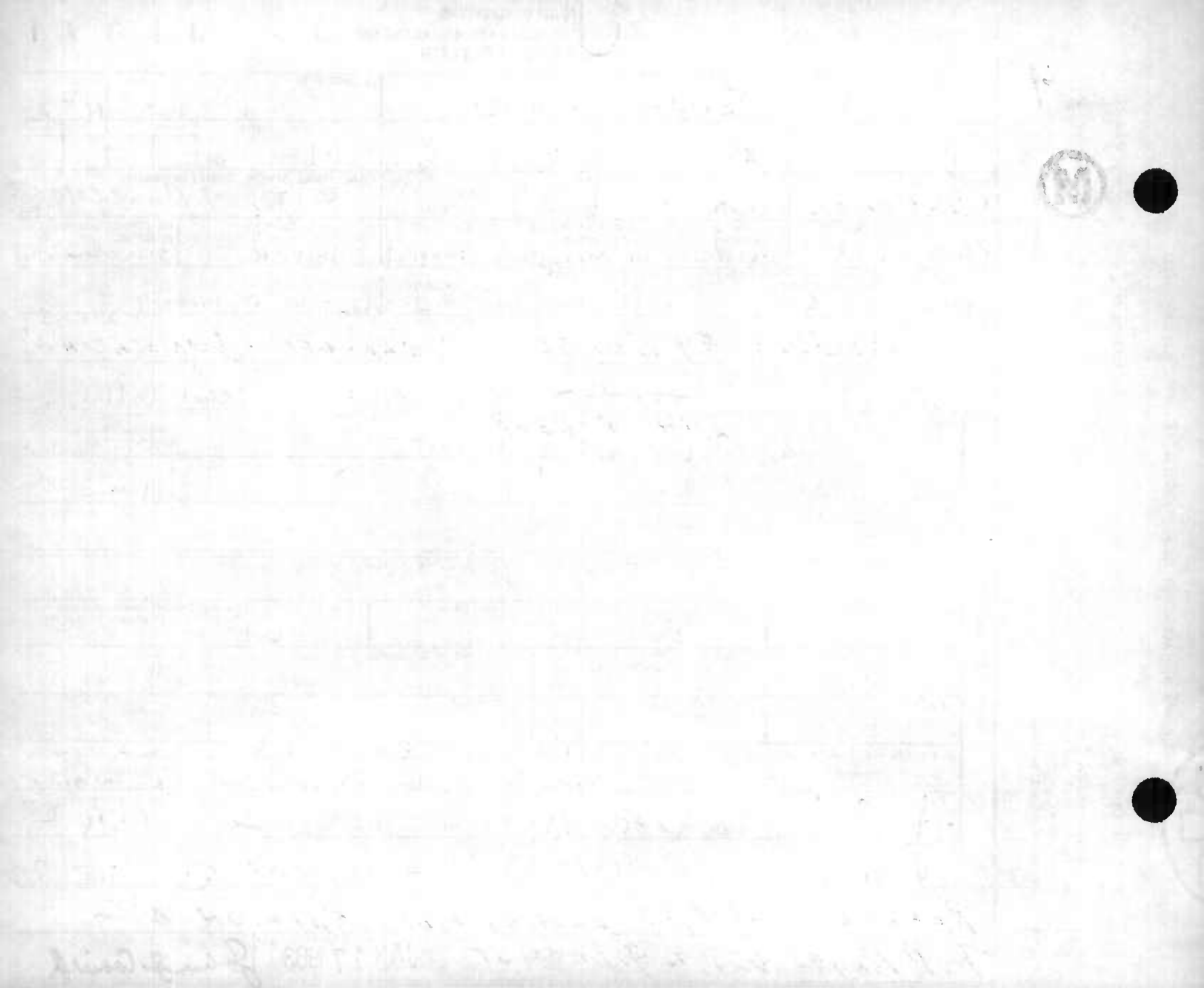
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 01091

REG. NO.

|  |   |   |  |  |   |
|--|---|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JONES SANDERS JONES</b>   |   |   | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>9</b> YEAR <b>83</b> 2b. HOUR <b>11:32</b> AM |  |   |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>B</b>   | 5. DATE OF BIRTH<br>MONTH <b>8</b> DAY <b>5</b> YEAR <b>21</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NORTH CAROLINA</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY OF BALTIMORE</b> MD                      |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIVERSITY OF MARYLAND HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>LABORER</b>       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Bethlehem Steel</b>                                     |
| 13a. STATE<br><b>MD</b>  |   |   | 13b. COUNTY<br><b>City</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST <b>Wm</b> MIDDLE <b>HURLEY</b> LAST <b>JONES</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>MICHAEL</b> MIDDLE <b>ANN</b> LAST <b>DUNNACAN</b>  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>228-17-403</b>   | 17. INFORMANT<br>ADDRESS<br><b>step-daughter Pearl C. Gillman</b>                        |  |   |
| 18. CAUSE OF DEATH (Enter only one cause for death, and if possible, the date of onset and duration of illness.)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1991</b> IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Metastatic Cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>One hour</b><br><b>1 month</b>               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>   |   |   |  |  |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |   |  |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/6</b> , 19 <b>83</b> , to <b>11/9</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death: <b>never saw pt alive pt came into ER in arrest</b>                              |   |   |  |  |   |
| 22b. SIGNATURE<br><b>Judith Minkove M.D.</b>   |   | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>1/5/82</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Judith Minkove</b>   |   | 22e. ADDRESS<br><b>22 S. Greene ST. BACT. 7124</b>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>REMOVAL</b>  |   | 23b. DATE<br><b>1/15/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>FAMILY PLOT</b>                             |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD</b>  |   | 25a. DATE RECEIVED BY REGISTRAR<br><b>JAN 17 1983</b>   |  |  |   |
| 24. FUNERAL DIRECTOR<br><b>Wm Hayes 635 W 9th mor st</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>   |  |  |   |

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |  | REG. NO. 8301092   |  |
|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>THADDEUS Earle JONES</b>  |  |   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JANUARY 19, 1983</b>   |  | 2b. HOUR<br><b>6:40 P.M.</b>                                   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>11 11 29</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.  |  | 7. IF UNDER 1 YEAR MONTHS DAYS  |  | 8. IF UNDER 24 HRS. HOURS MIN.                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington D.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> MD.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GOOD SAMARITAN HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br><b>WOODWORKER</b>   |  | 12b. KIND OF BUSINESS OR SERVICE<br><b>Self</b>   |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>Calvert</b>  |  | 13c. CITY OR TOWN<br><b>PORT REPUBLIC</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>22 Acacia</b><br><b>SCIENTIST'S CLIFF</b> <b>20676</b>  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Frank Jones</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Nellie Trazzare</b>  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>WW II</b>   |  | 17. INFORMANT<br><b>Ann Jones</b>   |  | ADDRESS<br><b>same as #13</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4920 IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST</b>   |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>MINUTES</b> |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>EMPHYSEMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |  |   |  |  |  |   |  | YEARS  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a   |  |  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>1-19-83</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>VENTILATOR-DEPENDENT</b>  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-5-83</b> , 19____, to <b>1-19-83</b> , 19____, that (I) (we) last saw the deceased alive on <b>1-19-83</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>   |  | DEGREE<br><b>MD, PhD</b>   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1-19-83</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DONNA PRZEPIDORKA</b>  |  |  |  | 22e. ADDRESS<br><b>600 N. WOLFE, BALTIMORE, MD 21205</b>  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1-22-1983</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Christ Church Cem</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Port Republic Calvert Md.</b>  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Donald V. Borgwardt</b>  |  |  |  | ADDRESS<br><b>Port Republic, Md. 20676</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 24 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John A. Givens</b>   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  | REG. NO.   |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CLARE A JORDAN</b>   |  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 23 83</b>  |  |  |  |  |
| 3. SEX<br><b>FEMALE</b>   |  |  |  |  | 4. RACE<br><b>WHITE</b>  |  |  |  |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 29 08</b>  |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b>   |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GOOD SAMARITAN</b> |  |  |  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  |  |  |  |
| 13a. STATE<br><b>MD</b>   |  |  |  |  | 13b. COUNTY<br><b>BALTO</b>  |  |  |  |  |
| 13c. CITY OR TOWN<br><b>21239</b>   |  |  |  |  | 13d. INS'DE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                    |  |  |  |  |
| 13e. STREET ADDRESS<br><b>6710 GLENKIRK RD.</b>   |  |  |  |  | 21239  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George E. Adams</b>  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Catherine Murray</b>   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>161-14-2649</b>   |  |  |  |  |
| 17. INFORMANT<br><b>John M. Jordan</b>  |  |  |  |  | ADDRESS<br><b>6710 Glenkirk Rd. 21239</b>  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4100</b> IMMEDIATE CAUSE (a) <b>Cardiac &amp; Resp. failure.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>EXTENSIVE M.I. ON 1-7-83.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>HCVD, E ANGINA</b> |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-7-83</b> 19 <b>83</b> , to <b>1-23-83</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1-23-83</b> 19 <b>83</b> at <b>5:58 PM</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.     |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>William E. Johnson</b>   |  |  |  |  | DEGREE<br><b>S.P. Dhillm. M.D.</b>   |  |  |  |  |
| 22c. DATE SIGNED<br><b>1-23-83.</b>   |  |  |  |  | 22d. ADDRESS<br><b>G.S. Hospital.</b>  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>Jan. 26, '83</b>                                       |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Joseph's Church</b>               |  |  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Maryland</b>  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 24 1983</b>                    |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>William E. Johnson</b>   |  |  | ADDRESS<br><b>8521 Loch Raven Blvd.</b>                                |  |  | REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>                                 |  |  |  |

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| 1912 |  | 1913 |  | 1914 |  | 1915 |  | 1916 |  | 1917 |  | 1918 |  | 1919 |  | 1920 |  | 1921 |  | 1922 |  | 1923 |  | 1924 |  | 1925 |  | 1926 |  | 1927 |  | 1928 |  | 1929 |  | 1930 |  | 1931 |  | 1932 |  | 1933 |  | 1934 |  | 1935 |  | 1936 |  | 1937 |  | 1938 |  | 1939 |  | 1940 |  | 1941 |  | 1942 |  | 1943 |  | 1944 |  | 1945 |  | 1946 |  | 1947 |  | 1948 |  | 1949 |  | 1950 |  | 1951 |  | 1952 |  | 1953 |  | 1954 |  | 1955 |  | 1956 |  | 1957 |  | 1958 |  | 1959 |  | 1960 |  | 1961 |  | 1962 |  | 1963 |  | 1964 |  | 1965 |  | 1966 |  | 1967 |  | 1968 |  | 1969 |  | 1970 |  | 1971 |  | 1972 |  | 1973 |  | 1974 |  | 1975 |  | 1976 |  | 1977 |  | 1978 |  | 1979 |  | 1980 |  | 1981 |  | 1982 |  | 1983 |  | 1984 |  | 1985 |  | 1986 |  | 1987 |  | 1988 |  | 1989 |  | 1990 |  | 1991 |  | 1992 |  | 1993 |  | 1994 |  | 1995 |  | 1996 |  | 1997 |  | 1998 |  | 1999 |  | 2000 |  | 2001 |  | 2002 |  | 2003 |  | 2004 |  | 2005 |  | 2006 |  | 2007 |  | 2008 |  | 2009 |  | 2010 |  | 2011 |  | 2012 |  | 2013 |  | 2014 |  | 2015 |  | 2016 |  | 2017 |  | 2018 |  | 2019 |  | 2020 |  | 2021 |  | 2022 |  | 2023 |  | 2024 |  | 2025 |  | 2026 |  | 2027 |  | 2028 |  | 2029 |  | 2030 |  | 2031 |  | 2032 |  | 2033 |  | 2034 |  | 2035 |  | 2036 |  | 2037 |  | 2038 |  | 2039 |  | 2040 |  | 2041 |  | 2042 |  | 2043 |  | 2044 |  | 2045 |  | 2046 |  | 2047 |  | 2048 |  | 2049 |  | 2050 |  | 2051 |  | 2052 |  | 2053 |  | 2054 |  | 2055 |  | 2056 |  | 2057 |  | 2058 |  | 2059 |  | 2060 |  | 2061 |  | 2062 |  | 2063 |  | 2064 |  | 2065 |  | 2066 |  | 2067 |  | 2068 |  | 2069 |  | 2070 |  | 2071 |  | 2072 |  | 2073 |  | 2074 |  | 2075 |  | 2076 |  | 2077 |  | 2078 |  | 2079 |  | 2080 |  | 2081 |  | 2082 |  | 2083 |  | 2084 |  | 2085 |  | 2086 |  | 2087 |  | 2088 |  | 2089 |  | 2090 |  | 2091 |  | 2092 |  | 2093 |  | 2094 |  | 2095 |  | 2096 |  | 2097 |  | 2098 |  | 2099 |  | 2100 |  | 2101 |  | 2102 |  | 2103 |  | 2104 |  | 2105 |  | 2106 |  | 2107 |  | 2108 |  | 2109 |  | 2110 |  | 2111 |  | 2112 |  | 2113 |  | 2114 |  | 2115 |  | 2116 |  | 2117 |  | 2118 |  | 2119 |  | 2120 |  | 2121 |  | 2122 |  | 2123 |  | 2124 |  | 2125 |  | 2126 |  | 2127 |  | 2128 |  | 2129 |  | 2130 |  | 2131 |  | 2132 |  | 2133 |  | 2134 |  | 2135 |  | 2136 |  | 2137 |  | 2138 |  | 2139 |  | 2140 |  | 2141 |  | 2142 |  | 2143 |  | 2144 |  | 2145 |  | 2146 |  | 2147 |  | 2148 |  | 2149 |  | 2150 |  | 2151 |  | 2152 |  | 2153 |  | 2154 |  | 2155 |  | 2156 |  | 2157 |  | 2158 |  | 2159 |  | 2160 |  | 2161 |  | 2162 |  | 2163 |  | 2164 |  | 2165 |  | 2166 |  | 2167 |  | 2168 |  | 2169 |  | 2170 |  | 2171 |  | 2172 |  | 2173 |  | 2174 |  | 2175 |  | 2176 |  | 2177 |  | 2178 |  | 2179 |  | 2180 |  | 2181 |  | 2182 |  | 2183 |  | 2184 |  | 2185 |  | 2186 |  | 2187 |  | 2188 |  | 2189 |  | 2190 |  | 2191 |  | 2192 |  | 2193 |  | 2194 |  | 2195 |  | 2196 |  | 2197 |  | 2198 |  | 2199 |  | 2200 |  | 2201 |  | 2202 |  | 2203 |  | 2204 |  | 2205 |  | 2206 |  | 2207 |  | 2208 |  | 2209 |  | 2210 |  | 2211 |  | 2212 |  | 2213 |  | 2214 |  | 2215 |  | 2216 |  | 2217 |  | 2218 |  | 2219 |  | 2220 |  | 2221 |  | 2222 |  | 2223 |  | 2224 |  | 2225 |  | 2226 |  | 2227 |  | 2228 |  | 2229 |  | 2230 |  | 2231 |  | 2232 |  | 2233 |  | 2234 |  | 2235 |  | 2236 |  | 2237 |  | 2238 |  | 2239 |  | 2240 |  | 2241 |  | 2242 |  | 2243 |  | 2244 |  | 2245 |  | 2246 |  | 2247 |  | 2248 |  | 2249 |  | 2250 |  | 2251 |  | 2252 |  | 2253 |  | 2254 |  | 2255 |  | 2256 |  | 2257 |  | 2258 |  | 2259 |  | 2260 |  | 2261 |  | 2262 |  | 2263 |  | 2264 |  | 2265 |  | 2266 |  | 2267 |  | 2268 |  | 2269 |  | 2270 |  | 2271 |  | 2272 |  | 2273 |  | 2274 |  | 2275 |  | 2276 |  | 2277 |  | 2278 |  | 2279 |  | 2280 |  | 2281 |  | 2282 |  | 2283 |  | 2284 |  | 2285 |  | 2286 |  | 2287 |  | 2288 |  | 2289 |  | 2290 |  | 2291 |  | 2292 |  | 2293 |  | 2294 |  | 2295 |  | 2296 |  | 2297 |  | 2298 |  | 2299 |  | 2300 |  | 2301 |  | 2302 |  | 2303 |  | 2304 |  | 2305 |  | 2306 |  | 2307 |  | 2308 |  | 2309 |  | 2310 |  | 2311 |  | 2312 |  | 2313 |  | 2314 |  | 2315 |  | 2316 |  | 2317 |  | 2318 |  | 2319 |  | 2320 |  | 2321 |  | 2322 |  | 2323 |  | 2324 |  | 2325 |  | 2326 |  | 2327 |  | 2328 |  | 2329 |  | 2330 |  | 2331 |  | 2332 |  | 2333 |  | 2334 |  | 2335 |  | 2336 |  | 2337 |  | 2338 |  | 2339 |  | 2340 |  | 2341 |  | 2342 |  | 2343 |  | 2344 |  | 2345 |  | 2346 |  | 2347 |  | 2348 |  | 2349 |  | 2350 |  | 2351 |  | 2352 |  | 2353 |  | 2354 |  | 2355 |  | 2356 |  | 2357 |  | 2358 |  | 2359 |  | 2360 |  | 2361 |  | 2362 |  | 2363 |  | 2364 |  | 2365 |  | 2366 |  | 2367 |  | 2368 |  | 2369 |  | 2370 |  | 2371 |  | 2372 |  | 2373 |  | 2374 |  | 2375 |  | 2376 |  | 2377 |  | 2378 |  | 2379 |  | 2380 |  | 2381 |  | 2382 |  | 2383 |  | 2384 |  | 2385 |  | 2386 |  | 2387 |  | 2388 |  | 2389 |  | 2390 |  | 2391 |  | 2392 |  | 2393 |  | 2394 |  | 2395 |  | 2396 |  | 2397 |  | 2398 |  | 2399 |  | 2400 |  | 2401 |  | 2402 |  | 2403 |  | 2404 |  | 2405 |  | 2406 |  | 2407 |  | 2408 |  | 2409 |  | 2410 |  | 2411 |  | 2412 |  | 2413 |  | 2414 |  | 2415 |  | 2416 |  | 2417 |  | 2418 |  | 2419 |  | 2420 |  | 2421 |  | 2422 |  | 2423 |  | 2424 |  | 2425 |  | 2426 |  | 2427 |  | 2428 |  | 2429 |  | 2430 |  | 2431 |  | 2432 |  | 2433 |  | 2434 |  | 2435 |  | 2436 |  | 2437 |  | 2438 |  | 2439 |  | 2440 |  | 2441 |  | 2442 |  | 2443 |  | 2444 |  | 2445 |  | 2446 |  | 2447 |  | 2448 |  | 2449 |  | 2450 |  | 2451 |  | 2452 |  | 2453 |  | 2454 |  | 2455 |  | 2456 |  | 2457 |  | 2458 |  | 2459 |  | 2460 |  | 2461 |  | 2462 |  | 2463 |  | 2464 |  | 2465 |  | 2466 |  | 2467 |  | 2468 |  | 2469 |  | 2470 |  | 2471 |  | 2472 |  | 2473 |  | 2474 |  | 2475 |  | 2476 |  | 2477 |  | 2478 |  | 2479 |  | 2480 |  | 2481 |  | 2482 |  | 2483 |  | 2484 |  | 2485 |  | 2486 |  | 2487 |  | 2488 |  | 2489 |  | 2490 |  | 2491 |  | 2492 |  | 2493 |  | 2494 |  | 2495 |  | 2496 |  | 2497 |  | 2498 |  | 2499 |  | 2500 |  | 2501 |  | 2502 |  | 2503 |  | 2504 |  | 2505 |  | 2506 |  | 2507 |  | 2508 |  | 2509 |  | 2510 |  | 2511 |  | 2512 |  | 2513 |  | 2514 |  | 2515 |  | 2516 |  | 2517 |  | 2518 |  | 2519 |  | 2520 |  | 2521 |  | 2522 |  | 2523 |  | 2524 |  | 2525 |  | 2526 |  | 2527 |  | 2528 |  | 2529 |  | 2530 |  | 2531 |  | 2532 |  | 2533 |  | 2534 |  | 2535 |  | 2536 |  | 2537 |  | 2538 |  | 2539 |  | 2540 |  | 2541 |  | 2542 |  | 2543 |  | 2544 |  | 2545 |  | 2546 |  | 2547 |  | 2548 |  | 2549 |  | 2550 |  | 2551 |  | 2552 |  | 2553 |  | 2554 |  | 2555 |  | 2556 |  | 2557 |  | 2558 |  | 2559 |  | 2560 |  | 2561 |  | 2562 |  | 2563 |  | 2564 |  | 2565 |  | 2566 |  | 2567 |  | 2568 |  | 2569 |  | 2570 |  | 2571 |  | 2572 |  | 2573 |  | 2574 |  | 2575 |  | 2576 |  | 2577 |  | 2578 |  | 2579 |  | 2580 |  | 2581 |  | 2582 |  | 2583 |  | 2584 |  | 2585 |  | 2586 |  | 2587 |  | 2588 |  | 2589 |  | 2590 |  | 2591 |  | 2592 |  | 2593 |  | 2594 |  | 2595 |  | 2596 |  | 2597 |  | 2598 |  | 2599 |  | 2600 |  | 2601 |  | 2602 |  | 2603 |  | 2604 |  | 2605 |  | 2606 |  | 2607 |  | 2608 |  | 2609 |  | 2610 |  | 2611 |  | 2612 |  | 2613 |  | 2614 |  | 2615 |  | 2616 |  | 2617 |  | 2618 |  | 2619 |  | 2620 |  | 2621 |  | 2622 |  | 2623 |  | 2624 |  | 2625 |  | 2626 |  | 2627 |  | 2628 |  | 2629 |  | 2630 |  | 2631 |  | 2632 |  | 2633 |  | 2634 |  | 2635 |  | 2636 |  | 2637 |  | 2638 |  | 2639 |  | 2640 |  | 2641 |  | 2642 |  | 2643 |  | 2644 |  | 2645 |  | 2646 |  | 2647 |  | 2648 |  | 2649 |  | 2650 |  | 2651 |  | 2652 |  | 2653 |  | 2654 |  | 2655 |  | 2656 |  | 2657 |  | 2658 |  | 2659 |  | 2660 |  | 2661 |  | 2662 |  | 2663 |  | 2664 |  | 2665 |  | 2666 |  | 2667 |  | 2668 |  | 2669 |  | 2670 |  | 2671 |  | 2672 |  | 2673 |  | 2674 |  | 2675 |  | 2676 |  | 2677 |  | 2678 |  | 2679 |  | 2680 |  | 2681 |  | 2682 |  | 2683 |  | 2684 |  | 2685 |  | 2686 |  | 2687 |  | 2688 |  | 2689 |  | 2690 |  | 2691 |  | 2692 |  | 2693 |  | 2694 |  | 2695 |  | 2696 |  | 2697 |  | 2698 |  | 2699 |  | 2700 |  | 2701 |  | 2702 |  | 2703 |  | 2704 |  | 2705 |  | 2706 |  | 2707 |  | 2708 |  | 2709 |  | 2710 |  | 2711 |  | 2712 |  | 2713 |  | 2714 |  | 2715 |  | 2716 |  | 2717 |  | 2718 |  | 2719 |  | 2720 |  | 2721 |  | 2722 |  | 2723 |  | 2724 |  | 2725 |  | 2726 |  | 2727 |  | 2728 |  | 2729 |  | 2730 |  | 2731 |  | 2732 |  | 2733 |  | 2734 |  | 2735 |  | 2736 |  | 2737 |  | 2738 |  | 2739 |  | 2740 |  | 2741 |  | 2742 |  | 2743 |  | 2744 |  | 2745 |  | 2746 |  | 2747 |  | 2748 |  | 2749 |  | 2750 |  | 2751 |  | 2752 |  | 2753 |  | 2754 |  | 2755 |  | 2756 |  | 2757 |  | 2758 |  | 2759 |  | 2760 |  | 2761 |  | 2762 |  | 2763 |  | 2764 |  | 2765 |  | 2766 |  | 2767 |  | 2768 |  | 2769 |  | 2770 |  | 2771 |  | 2772 |  | 2773 |  | 2774 |  | 2775 |  | 2776 |  | 2777 |  | 2778 |  | 2779 |  | 2780 |  | 2781 |  | 2782 |  | 2783 |  | 2784 |  | 2785 |  | 2786 |  | 2787 |  | 2788 |  | 2789 |  | 2790 |  | 2791 |  | 2792 |  | 2793 |  | 2794 |  | 2795 |  | 2796 |  | 2797 |  | 2798 |  | 2799 |  | 2800 |  | 2801 |  | 2802 |  | 2803 |  | 2804 |  | 2805 |  | 2806 |  | 2807 |  | 2808 |  | 2809 |  | 2810 |  | 2811 |  | 2812 |  | 2813 |  | 2814 |  | 2815 |  | 2816 |  | 2817 |  | 2818 |  | 2819 |  | 2820 |  | 2821 |  | 2822 |  | 2823 |  | 2824 |  | 2825 |  | 2826 |  | 2827 |  | 2828 |  | 2829 |  | 2830 |  | 2831 |  | 2832 |  | 2833 |  | 2834 |  | 2835 |  | 2836 |  | 2837 |  | 2838 |  | 2839 |  | 2840 |  | 2841 |  | 2842 |  | 2843 |  | 2844 |  | 2845 |  | 2846 |  | 2847 |  | 2848 |  | 2849 |  | 2850 |  | 2851 |  | 2852 |  | 2853 |  | 2854 |  | 2855 |  | 2856 |  | 2857 |  | 2858 |  | 2859 |  | 2860 |  | 2861 |  | 2862 |  | 2863 |  | 2864 |  | 2865 |  | 2866 |  | 2867 |  | 2868 |  | 2869 |  | 2870 |  | 2871 |  | 2872 |  | 2873 |  | 2874 |  | 2875 |  | 2876 |  | 2877 |  | 2878 |  | 2879 |  | 2880 |  | 2881 |  | 2882 |  | 2883 |  | 2884 |  | 2885 |  | 2886 |  | 2887 |  | 2888 |  | 2889 |  | 2890 |  | 2891 |  | 2892 |  | 2893 |  | 2894 |  | 2895 |  | 2896 |  | 2897 |  | 2898 |  | 2899 |  | 2900 |  | 2901 |  | 2902 |  | 2903 |  | 2904 |  | 2905 |  | 2906 |  | 2907 |  | 2908 |  | 2909 |  | 2910 |  | 2911 |  | 2912 |  | 2913 |  | 2914 |  | 2915 |  | 2916 |  | 2917 |  | 2918 |  | 2919 |  | 2920 |  | 2921 |  | 2922 |  | 2923 |  | 2924 |  | 2925 |  | 2926 |  | 2927 |  | 2928 |  | 2929 |  | 2930 |  | 2931 |  | 2932 |  | 2933 |  | 2934 |  | 2935 |  | 2936 |  | 2937 |  | 2938 |  | 2939 |  | 2940 |  | 2941 |  | 2942 |  | 294 |  |
|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 83 01094   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>BERTHA LILLIAN JUSTICE</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 1 31 83  |  |   |  |
| 3. SEX <b>FEMALE</b>  |  | 4. RACE <b>CAUCASIAN</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR 3 9 1907  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. AGNES HOSPITAL</b>                            |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>MD</b>  |  |   |  | 13b. CITY OR TOWN <b>BALTIMORE</b>  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO. <b>216-72-2984</b>   |  | 17. INFORMANT ADDRESS <b>FRANKLIN C. JUSTICE 1718 ARLINGTON AVE. 21227</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4280 IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CONGESTIVE HEART FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>NO</b>  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that I (this hospital) attended the deceased from <b>30 Jan</b> 19 <b>83</b> to <b>31 Jan</b> 19 <b>83</b> , that I (we) last saw the deceased alive on <b>31 Jan</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did not) view the body after death.                                      |  |   |  |   |  |   |  |
| 22b. SIGNATURE <b>Andrew F. Troft</b>   |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED <b>1/31/83</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANDREW TROFT</b>   |  | 22e. ADDRESS <b>900 CARON AVE. BALTIMORE, MD</b>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  | 23b. DATE <b>02-02-83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b>  |  |
| 24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b>   |  | ADDRESS <b>4107 WILKENS AVE.</b>  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 2 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  | REG. NO. |  |
|---|--|---|--|---|--|---|--|--|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Spirydon Kaczmarek   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 15 1983             |   |  | 2b. HOUR<br>3:30PM   |  |          |  |
| 3 SEX<br>Male   |  | 4 RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>January 18 1914   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ukraine  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>Ukraine   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |  |          |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2205 Bank Street |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Mechanic                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Rubber Factory  |  |          |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>---  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>2205 Bank Street 21231  |  |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ivan Kaczmarek  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anastasia Nazarek |   |  |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>no  |  |   |  | 16b. SOCIAL SECURITY NO.<br>215-46-7543   |  | 17. INFORMANT<br>ADDRESS<br>Jan Kaczmarek 802 Dellwood Drive                                    |  |  |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>1990 IMMEDIATE CAUSE (a) <u>Carcinomatous</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.             |  |   |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 months   |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>CHRONIC LYMPHOCYTIC LEUKEMIA</u>  |  |   |  |   |  |   |  |  |  |          |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/10/77</u> , 19 <u>83</u> , to <u>1/15</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>1/13</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |  |  |          |  |
| 22b. SIGNATURE<br><u>Henry J. Houska MD</u>   |  |   |  |   | DEGREE   |   | 22c. DATE SIGNED<br>1/17/83                                      |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>HENRY J. HOUSKA MD</u>  |  |   |  |   | 22e. ADDRESS<br><u>333 S CAST AVE BALTO 21224 MD</u>               |   |  |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   | 23b. DATE<br>Jan. 18 1983  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Michael Ukr. Cem.        |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland |  |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Lilly & Zeiler, Inc. 1901 Eastern Ave. 21231  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 17 1983  |  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Carver</u>  |  |          |  |

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |   |  |  |  |   |   |  |
|--|--|--|---|--|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>EDWARD L. KAISERSKI</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 23 83</b>                   |  |  | 2b. HOUR<br><b>6:45 A.M.</b>   |   |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>January 21, 1913</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 9. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |   |   |  |
| 12. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BON SECOURS HOSPITAL</b> |   |  |  | 14. USUAL RESIDENCE (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ACCOUNTANT</b>   |   | 15. KIND OF BUSINESS OR INDUSTRY<br><b>STATE OF MD.</b>   |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>3a. STATE<br><b>MARYLAND</b>  |  | 17. CITY OR TOWN<br><b>BALTIMORE</b>   |   | 18. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 19. STREET ADDRESS<br><b>20 DUTTON AVENUE 21228</b>  |   |   |  |
| 20. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HERMAN W. KAISERSKI</b>   |  |  | 21. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ANTOINETTE LONG</b> |  |  |  |   |   |  |
| 22. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 23. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>212-01-7280</b>  |   | 24. INFORMANT ADDRESS<br><b>MRS. LOIS S. KAISERSKI SAME AS # 13</b>  |  |  |   |   |  |
| 25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br><b>4149</b> IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CORONARY ARTERY DISEASE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <b>AORTIC STENOSIS</b> |  |  |   |  |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |  |  |  |   |   |  |
| 26. DATE OF OPERATION  |  |  | 27. CONDITION FOR WHICH OPERATION WAS PERFORMED                         |  |  | 28. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 29. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 30. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 31. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>        |  |  | 32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |
| 33. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 34. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 35. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |
| 36. I certify that (I) (this hospital) attended the deceased from <b>1-23</b> 19 <b>83</b> , to <b>1-23</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>NOV</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.               |  |  |   |  |  |  |   |   |  |
| 37. SIGNATURE<br><b>FREDERICK J. SUTTON</b>  |  |  | 38. DEGREE<br><b>M.D.</b>   |  |  | 39. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 40. DATE SIGNED<br><b>1-23-83</b>   |  |
| 41. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>FREDERICK J. SUTTON</b>   |  |  | 42. ADDRESS<br><b>225 GREENE ST BALTIMORE</b>                           |  |  |  |   |   |  |
| 43. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |  | 44. DATE<br><b>1/26/83</b>  |  | 45. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK CEMETERY</b> |  | 46. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD.</b> |   |  |
| 47. FUNERAL DIRECTOR'S NAME<br><b>LEROY M. &amp; RUSSELL C. WITZKE FUNERAL HOME</b>  |  |  | 48. ADDRESS<br><b>1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228</b>     |  | 49. DATE REC'D. BY REGISTRAR<br><b>JAN 26 1983</b>               |  | 50. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, unless any injury, or other traumatic event, or medical condition must be stated on this page.

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DATE

JANUARY 11 1972

TIME

NO.

UNITED STATES

DEPARTMENT OF

DEFENSE

WASHINGTON

OFFICE OF THE SECRETARY

OF THE ARMY

NO.

DATE

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OFFICE OF THE SECRETARY

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OFFICE OF THE SECRETARY

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OFFICE OF THE SECRETARY

OF THE ARMY

NO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

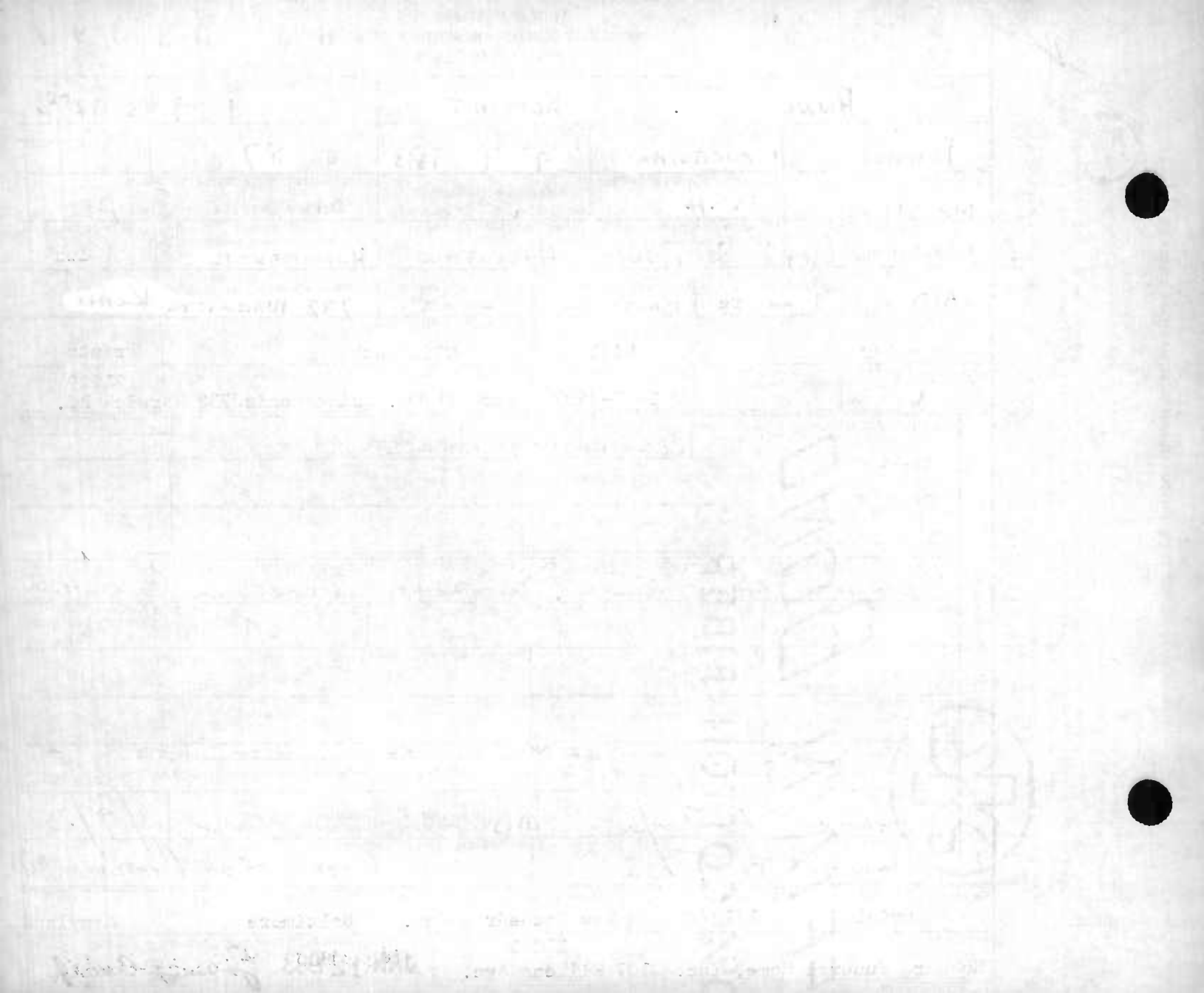
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |  |  |  |  |                                    |
|--|--|---|--|---|---|--|--|--|--|------------------------------------|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 783 01097<br>REG. NO.   |  |   |   |  |  |  |  |                                    |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ANNE T. KEATING   |  |   |  |   | 7a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 9 83                     |  |  |  |  | 2b. HOUR<br>12 <sup>05</sup> P. M. |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 1 1895  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |                                    |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE City. MD.  |  |  |  |                                    |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. AGNES HOSPITAL |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>---   |  |                                    |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Kensington   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br>732 Warwick Road 21229  |  |                                    |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Kiel  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth Printz |  |  |  |  |                                    |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-05-5697  |  | 17. INFORMANT<br>ADDRESS<br>Veronica A. Kristaponis 732 Warwick Rd. 21229   |   |  |  |  |  |                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>4280 IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.      |  |   |  |   |   |  |  |  |  |                                    |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>CONGESTIVE HEART FAILURE, DISSEMINATED INTRAVASCULAR COAGULATION.</u>  |  |   |  |   |   |  |  |  |  |                                    |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                    |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |  |                                    |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |                                    |
| 22a. certify that (I) (this hospital) attended the deceased from <u>22 NOV</u> , 19 <u>82</u> , to <u>9 Jan</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>9 JAN</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |  |  |  |  |                                    |
| 22b. SIGNATURE<br><u>Andrew F. Tropa</u>   |  |   |  | DEGREE<br>MD  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>1/9/83   |  |                                    |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Andrew F. Tropa   |  |   |  | 22e. ADDRESS<br>900 CAYON AVE. BALTIMORE, MD  |   |  |  |  |  |                                    |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>1/12/83  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cem.  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland   |  |  |  |                                    |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.   |  |   |  | ADDRESS<br>21229  |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 12 1983   |  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Canine</u>  |  |                                    |

MEDICAL CERTIFICATION



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 0 9 8

|  |  |   |  |
|--|--|---|--|
| FOR<br>1 - STATE REGISTRAR   |  | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | 2a. DATE OF DEATH   |  |
| FIRST MIDDLE LAST<br><b>LOTTIE KEDZIOR</b>   |  | MONTH DAY YEAR<br><b>JANUARY 4, 1983</b>  |  |
| 3. SEX<br><b>Female</b>  |  | 2b. HOUR<br><b>11:00AM</b>  |  |
| 4. RACE<br><b>White</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 3 1898</b>  |  | <b>84</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Hospital Corporation</b>             |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. CITY OR TOWN<br><b>Dundalk</b>   |  |
| 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13d. STREET ADDRESS<br><b>3120 Wallford Dr. Apt. B</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>J. Pacanowski</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Pniewski</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO. <b>A 215-03-5011</b>   |  |
| 17. INFORMANT<br><b>Marie Sterling</b>   |  | 3120 Wallford Dr. Apt. B<br>Balto., MD. 21222   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE CEREBROVASCULAR ACCIDENT</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/2/83</b> to <b>1/4/83</b> , that (I) (we) last saw the deceased alive on <b>1/4/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.  |  |   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>W. IMPAGLIATELLI, M.D.</b>   |  | 22c. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION<br/>100 N. BROADWAY BALTIMORE, MD. 21231</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/7/1983</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Stanislaus</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Duda-Ruck, Inc.</b>   |  | 25a. DATE REC'D. BY REGISTRAR   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>  |  | 25c. ADDRESS<br><b>79 22 Wise Avenue Dundalk, MD. 21222</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the county after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

NO. 1000 12142  
STATION 10141000  
STATION 10141000



STATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |  |   |   |  |
|---|--|--|--|---|--|--|---|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   | 8 3 0 1 0 9 9  |  |   |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  |   | 2a. DATE OF DEATH  |  |   |   |  |
| FIRST MIDDLE LAST   |  |  |  |   | MONTH DAY YEAR HOUR                                      |  |   |   |  |
| JOSEPH Vincent KEENAN Sr.   |  |  |  |   | 1 12 83 2 A M  |  |   |   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | 7. IF UNDER 1 YEAR                      |  |
| MALE  |  | CAUCASIAN  |  | MONTH DAY YEAR  |  | 62 YRS   |   | MONTHS DAYS HOURS MIN.                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |   |  |
| MD.   |  | USA  |  |   |  | BALTIMORE CITY MD.   |   |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY       |  |
| BALTIMORE   |  | UNIVERSITY OF MARYLAND HOSPITAL  |  |   |  | MOTOR REPAIR   |   | ELECTRIC CO.                            |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY/TOWN  |  | 13d. INSIDE CITY LIMITS?   |   | 13e. STREET ADDRESS                     |  |
| MD  |  | HARFORD  |  | BEL AIR   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 1300 SARATOGA DRIVE 21014               |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS                   |  |
| JAMES Albert  |  | FLORENCE   |  | Yes   |  | 21014-3804   |   | Mrs. Janet Keenan, Broomfield, Colorado |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |  |  |   |   |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |   |  |  |   |   |  |
| 4292 IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST  |  |  |  |   |  |  |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |  |   |   |  |
| (b) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE  |  |  |  |   |  |  |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |  |   |   |  |
| (c)   |  |  |  |   |  |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):  |  |  |  |   |  |  |   |   |  |
| ACUTE RENAL FAILURE   |  |  |  |   |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |   |  |
|   |  |  |  |   | YES <input type="checkbox"/> NO <input type="checkbox"/> |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |   |   |  |
|   |  | P.M. 19  |  |   |  |  |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |   |   |  |
|   |  |  |  |   |  |  |   |   |  |
| 22a. I certify that (if this hospital) attended the deceased from 12/29/82 to 1/12/83, that (we) last saw the deceased alive on 1/12/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (if (we) (did) (did not) view the body after death. |  |  |  |   |  |  |   |   |  |
| 22b. SIGNATURE  |  | DEGREE   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED                        |  |
| Paul C. Shakin MD   |  |  |  |   |  |  |   | 1/12/83                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |   |  |  |   |   |  |
| PAUL C. SHAKIN  |  | 22 S. GREENE ST., BALTIMORE, MD.   |  |   |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |   |   |  |
| Burial  |  | Jan. 15, 1983  |  | Bel Air Memorial Gardens, Bel Air   |  | Harford Md.  |   |   |  |
| 24. FUNERAL DIRECTOR NAME   |  | ADDRESS  |  | 25a. DATE REG'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |   |   |  |
| Howard K. McComas III, Abingdon, Md. 21009  |  |  |  | JAN 17 1983   |  | John J. Connel   |   |   |  |

BP



100% COLLECT



100% COLLECT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post a copy in the retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP

DHMH-16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8301100

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |  |  |   |  |  |
|--|--|--|---|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Kenneth Theodore Keeney</b><br><b>Kenneth T. KEENEY</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-24-83</b>                             |   |  | 2b. HOUR<br><b>5:35 AM</b>   |   |  |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1-09-09</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>BALTO. Md</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balt City</b> MD.   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SE AGNES HOSP.</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Postal work</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Post office</b>  |  |
| 13a. STATE<br><b>Md</b>  |  |  | 13b. COUNTY<br><b>Balto.</b>  |   | 13c. CITY OR TOWN<br><b>Balto.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Oliver Keeney</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mrs. Arbutus Iler</b>         |   |  | 13e. STREET ADDRESS<br><b>2901 Vermont Ave</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II 213021626</b> |   |  | 16c. ADDRESS<br><b>Mrs. Arbutus, 2901 Vermont Ave</b>  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>1919 Glioblastoma multiform</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 yrs</b> |  |  |   |   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a  |  |  |   |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                 |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)            |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/14</b> 19 <b>82</b> , to <b>1/24</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1/23</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.   |  |  |   |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>G. Hallice</b> M.D.   |  |  | DEGREE<br><b>M.D.</b>   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1/24/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GALLEN HALLICE</b>   |  |  | 22e. ADDRESS<br><b>St Agnes Hosp. Balt. Md.</b>                                   |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>Jan. 27, 1983</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oakland Cemetery</b>                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Oakland-Garrett- Md.</b>                       |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Starling Funeral Home</b>   |  |  | 25a. DATE REC'D BY REGISTRAR<br><b>JAN 25 1983</b>                                |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Covich</b>  |   |  |  |

136 Edmonston Ave. Catonsville, Md. 21228



RECEIVED 10/10/50

10/10/50

JAN 25 1953  
J. R. G. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

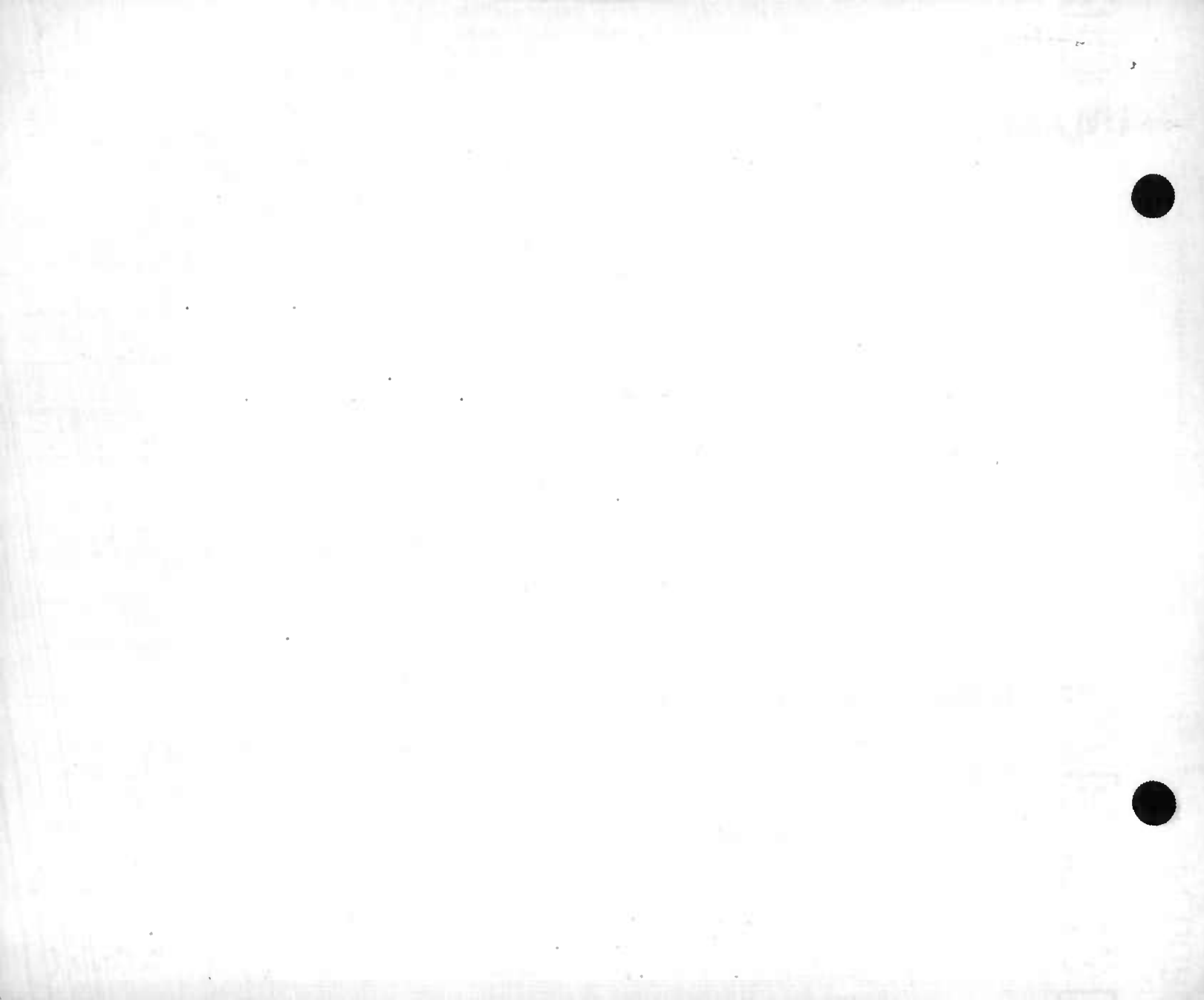
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 1 0 1

REG. NO.

|   |  |   |   |   |  |   |  |  |   |  |                               |  |
|---|--|---|---|---|--|---|--|--|---|--|-------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>YETTA KEHN</b>   |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>1/26/83</b>                        |   |  | 2b HOUR<br><b>6:53 P.M.</b>   |  |  |   |  |                               |  |
| 3 SEX<br><b>FEMALE</b>  |  | 4 RACE<br><b>WHITE</b>  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JUNE 6, 1917</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.                                    |  | 7a IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>65</b>   |   | 7b IF UNDER 24 HRS<br>HOURS MIN<br><b>65</b>       |                               |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |  |  |   |  |                               |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |   |   |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> |  |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>  |  |                               |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>MARYLAND</b>   |  |   | 13b COUNTY<br><b>BALTIMORE</b>  |   | 13c CITY OR TOWN<br><b>BALTIMORE</b>                               |   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS<br><b>501 W. 27TH ST. #21211</b> |  |                               |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ABRAHAM EXLER</b>   |  |   |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MOLLIE FRADIN</b>  |  |   |  |  |   |  |                               |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |   | 16b SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>214-01-0023</b> |   | 17 INFORMANT<br><b>MR. FRANK KEHN</b>                              |   |  | 17a ADDRESS<br><b>501 W. 27th ST. BALTO., MD</b>   |   |  | 17b PHONE NO.<br><b>21211</b> |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiac arrhythmia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Hypoxia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Right upper lobe pneumonia</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>30 mins</b><br><b>5 days</b> |  |   |   |   |  |   |  |  |   |  |                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Chronic obstructive pulmonary disease</b>  |  |   |   |   |  |   |  |  |   |  |                               |  |
| 19a DATE OF OPERATION<br><b>N/A</b>   |  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>H/A</b>               |   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                  |   |  |                               |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M.</b>               |   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |   |  |                               |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)       |   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |   |  |                               |  |
| 22a I certify that (1) (this hospital) attended the deceased from <b>Jan 22, 1983</b> to <b>Jan 26, 1983</b> , that (1) (we) lost saw the deceased alive on <b>Jan 26, 1983</b> , and that in (my) <b>our</b> opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.   |  |   |   |   |  |   |  |  |   |  |                               |  |
| 22b SIGNATURE<br><b>John A. Shutta M.D.</b>   |  |   |   |   |  | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c DATE SIGNED<br><b>1/26/83</b>                  |                               |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John A. Shutta M.D.</b>  |  |   |   |   |  | 22e ADDRESS<br><b>Union Memorial Hosp, Balt., Md.</b>                               |  |  |   |  |                               |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |   | 23b DATE<br><b>JAN. 28, 1983</b>  |   | 23c NAME OF CEMETERY OR CREMATORY<br><b>FRIEDEL MARYLAND LODGE</b> |   |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROSEDALE BALTO. MD</b>   |   |  |                               |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>  |  |   |   |   |  | ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>                            |  | 25a DATE REC'D. BY REGISTRAR<br><b>FEB 1 1983</b>  |   | 25b REGISTRAR'S SIGNATURE<br><b>John J. Connel</b> |                               |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 1 0 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |  |  |  |  |  |  |  |
|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   |  | 2a. DATE OF DEATH  |  |  | 2b. HOUR   |  |  |
| AMANDA KENDLER   |   |  | 01 12 83   |  |  | 12:41p M   |  |  |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |  | 7. IF UNDER 1 YEAR   |  |  |
| FEMALE   | WHITE   | MONTH DAY YEAR<br>09 25 1893   | 89 YRS.  |  |  | MONTHS DAYS HOURS MIN.   |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                   |  |  |  |  |  |
| MARYLAND   | U.S.A.  |  | BALTIMORE CITY MD.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)       |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| BALTIMORE  | ST. AGNES HOSPITAL  |  | BOX MAKER  |  |  | GLASS CO.  |  |  |
| 13a. STATE   |   |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN  |  |  |
| MARYLAND   |   |  | ---  |  |  | BALTIMORE  |  |  |
| 14. FATHER'S NAME  |   |  | 15. MOTHER'S MAIDEN NAME   |  |  | 16. STREET ADDRESS   |  |  |
| CHARLES KENDLER  |   |  | NELLIE UNKNOWN   |  |  | 1620 DE SOTO ROAD, 21230   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |   |  | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT  |  |  |
| NO   |   |  | 216-22-3722  |  |  | BETTIE ASPELMEYER 1620 DE SOTO ROAD, 21230                                     |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>5119 IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Bilateral pleural effusion</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Diabetes Mellitus, Gangrene R foot</u>  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| none   |   |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9th Jan 1983</u> to <u>12th Jan 1983</u> , that (I) (we) last saw the deceased alive on <u>12th Jan 1983</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |   |  |  |  |  | 22c. DATE SIGNED   |  |  |
| <u>I. JAVED</u> M.D.   |   |  |  |  |  | 1/12/83  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE)   |   |  |  |  |  | 22e. ADDRESS   |  |  |
| I. JAVED   |   |  |  |  |  | St. Agnes Hospital Baltimore M.D. 21229  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |   |  | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |
| BURIAL   |   |  | 01-14-83   |  |  | CEDAR HILL   |  |  |
| 24. FUNERAL DIRECTOR   |   |  | 25a. DATE REC'D. BY REGISTRAR  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |
| HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.   |   |  | JAN 17 1983  |  |  | <u>John J. Conner</u>  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





11/11/11  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

## MEDICAL CERTIFICATION

| FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 8301103   |  |   |  |
|--|--|--|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>BEATRICE KENIGSON</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JANUARY 9, 1983</b>  |  |   |  | 2b. HOUR<br><b>6 AM</b>  |  |   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>JUNE 13, 1898</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.                                   |  | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                   |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>100 W. COLDSRING LANE APT. 104E</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HOMEMAKER</b>  |  |   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>100 W. COLDSRING LA. (21210)</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>TOBIAS I SWARTZ</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>ANNA COHN</b>  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>216-01-5841 B</b>  |  | 17. INFORMANT ADDRESS (21210)<br><b>GEORGE KENIGSON 100 W. COLDSRING LANE #104E</b> |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>3320 IMMEDIATE CAUSE (a) ? pulmonary embolus</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>PARKINSON'S DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>12 years</b> |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>0</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>SENILE ATHEROSCLEROSIS</b>   |  |  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)      |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                      |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>25 OCT 1982</b> to <b>9 JAN 1983</b> , that (I) (we) last saw the deceased alive on <b>25 OCT 1982</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Abraham Gencin MD</b>   |  |  |  | DEGREE<br><b>MD</b>   |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/10/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ABRAHAM GENECIN</b>  |  |  |  | 22e. ADDRESS<br><b>611 PARK AVE. BALTIMORE, MD.</b>   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>CREMATION</b>  |  |  |  | 23b. DATE<br><b>1/11/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>London Park</b>                            |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTO. MD</b>  |  |   |  |
| 24. FUNERAL DIRECTOR'S NAME<br><b>SOL LEVINSON &amp; BROS.</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 18 1983</b>                                 |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. G. Smith</b>   |  |   |  |
| 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)   |  |  |  |   |  |   |  |  |  |   |  |



20% COLT

CHIEFMAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as a police officer.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   | 8 3 0 1 1 0 4   |  |  |  |                      |
|---|--|---|--|---|---|--|--|--|----------------------|
| 1. FOR STATE REGISTRAR  |  |   |  |   | REG. NO.  |  |  |  |                      |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Carrie Bell Kennedy  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 23, 1983   |  |  |  | 2b. HOUR<br>4:05a.m. |
| 3. SEX<br>Female  |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>August 31, 1886   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>96 years old YRS.                                 |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |                      |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |  |  |                      |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>General German Aged Peoples Home |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |                      |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |                      |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>---  |  | 13c. CITY OR TOWN<br>Baltimore  |   | 13e. STREET ADDRESS<br>1120 Plover Drive 21227                                       |  |  |                      |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Benjamin Phillippi  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna LeMaster         |   |   |  |  |  |                      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  |   | 16b. SOCIAL SECURITY NO.<br>215-48-0557                                |   | 17. INFORMANT<br>General German Aged Peoples Home<br>22 S. Athol Avenue Baltimore, MD 21229     |  |  |  |                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4254 } DUE TO, OR AS A CONSEQUENCE OF<br>(b) } DUE TO, OR AS A CONSEQUENCE OF<br>(c) }<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>Chronic cardiac failure |  |   |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |   |  |  |  |                      |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |                      |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |                      |
| 22a. I certify that (I) (this hospital) attended the deceased from June 23, 1983, to Jan 23, 1983, that (I) (we) last saw the deceased alive on Jan 23, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                              |  |   |  |   |   |  |  |  |                      |
| 22b. SIGNATURE<br>William J. Bryson M.D.  |  |   |  |   | DEGREE<br>M.D.  |  |  | 22c. DATE SIGNED<br>24 Jan 83  |                      |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>William J. Bryson  |  |   |  |   | 22e. ADDRESS<br>5772 Westview Mall  |  |  |  |                      |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |   | 23b. DATE<br>Jan. 25, 1983   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Memorial Park Dorsey Howard                   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland |  |                      |
| 24. FUNERAL DIRECTOR<br>NAME Loring Byers Funeral Directors, INC.<br>ADDRESS 8728 Liberty Road Randallstown, MD 21133-4784  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 25 1983  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Connel                     |  |                      |

BP

RECEIVED  
JAN 10 1900  
U.S. DEPT. OF AGRICULTURE  
WASHINGTON, D.C.



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WHITE PAPER

20% COTTON

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |         |   |  |  |  |   |                                      |                                   |   | REG. NO. 83 01105  |  |          |
|--|---------|---|--|--|--|---|--------------------------------------|-----------------------------------|---|--|--|----------|
| 1- FOR STATE REGISTRAR   |         |   |  |  |  |   |                                      |                                   |   | 2a. DATE KNOWN OF DEATH  |  | 2b. HOUR |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>George Walter Kenney   |         |   |  |  |  |   |                                      |                                   |   | ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>1 7 1983   |  | M        |
| 3 SEX  | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                      | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.  |   | 7c. DATE PRONOUNCED DEAD             |                                   | 24 HOUR                                 |  |  |          |
| Male   | White   | 11/21/1922  |  | 60 YRS.  |  |   | 1 7 1983                             |                                   | 8:45 a.m.                               |  |  |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH |                                   |   |  |  |          |
| Maryland   |         | USA   |  |  |  |   | Baltimore City, MD.                  |                                   |   |  |  |          |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |                                      | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |  |          |
| Baltimore  |         | University Hospital - STU   |  |  |  | Employee State Mosq. Control  |                                      |                                   |   |  |  |          |
| 13a. STATE   |         | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                     |                                      | 13e. STREET ADDRESS               |   |  |  |          |
| Maryland   |         | Wicomico  |  | Mardela  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                      | Rt. 1, Box 770 21837              |   |  |  |          |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |         |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |   |                                      |                                   |   |  |  |          |
| George Washington Kenney   |         |   |  |  | Ruth Naomi Dickerson   |   |                                      |                                   |   |  |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |         |   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT (wife) ADDRESS  |                                      |                                   |   |  |  |          |
| No   |         |   |  | 220-12-0901  |  | Mrs. Stella B. Kenney same as #13   |                                      |                                   |   |  |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>9552 IMMEDIATE CAUSE (a) Gunshot wound of Head with complications<br>(b) _____<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. |         |   |  |  |  |   |                                      |                                   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |         |   |  |  |  |   |                                      |                                   |   |  |  |          |
| 19a. DATE OF OPERATION   |         |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                    |  |   |                                      |                                   |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |          |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |   |  | 21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR<br>1:00 P.M. 11 12 1982 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject shot himself |                                      |                                   |   |  |  |          |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |         |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>Home  |  | 21f. LOCATION - STREET CITY OR TOWN COUNTY STATE<br>Rt. 1, Box 770, Mardella, Wicomico Co., Md.       |                                      |                                   |   |  |  |          |
| 22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>       |         |   |  |  |  |   |                                      |                                   |   | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |          |
| ACTUAL SIGNATURE   |         |   |  | TITLE (SPECIFY)<br>Assistant MEDICAL EXAMINER                        |  |   |                                      |                                   |   | DATE SIGNED 1-7-83   |  |          |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |   |  | ADDRESS  |  |   |                                      |                                   |   |  |  |          |
| Dennis F. Smyth, M.D.  |         |   |  | 111 Penn Street  |  |   |                                      |                                   |   |  |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         |   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |                                      |                                   | 23d. LOCATION CITY OR TOWN COUNTY STATE |  |  |          |
| Burial   |         |   |  | 1/9/83   |  | Springhill Mem. Gardens   |                                      |                                   | Salisbury, Wic. Maryland                |  |  |          |
| 24. FUNERAL DIRECTOR NAME ADDRESS  |         |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR (DATE) REGISTRAR'S SIGNATURE  |                                      |                                   |   |  |  |          |
| HOLLOWAY FUNERAL HOME, Salisbury, Md.  |         |   |  |  |  | JAN 12 1983 John J. Lauer   |                                      |                                   |   |  |  |          |

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THE NATIONAL ARCHIVES  
COLLEGE PARK, MARYLAND 20740  
SERIALS ACQUISITION SECTION



COPIES

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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|   |   |   |  |
|---|---|---|--|
| 1. FOR STATE REGISTRAR  |   | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Marie E. Kenny</b>   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1/29/83</b>                                      |  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Nov. 27, 1911</b>                                 |  |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7a. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>821 W. 35th Street 21211</b> | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Production</b>      | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Cotton Mill</b>  |
| 13a. STATE<br><b>Md.</b>  |   | 13b. CITY OR TOWN<br><b>Baltimore</b>   | 13c. STREET ADDRESS<br><b>821 W. 35th Street 21211</b>   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Walter Hubbs</b>  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Effie Painter</b>                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>no</b>  |   | 16b. SOCIAL SECURITY NO<br><b>213 03 5571</b>   |  |
| 17. INFORMANT ADDRESS<br><b>Rose Lubitz 6822 Parsons Avenue 21207</b>   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Coronary occlusion</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Coronary Artery Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>10 years</b> |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hr</b>                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)   |   |   |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 10/ 19 42</b> to <b>1/29 19 83</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                     |   |   |  |
| 22b. SIGNATURE<br><b>Leonard Wallenstein</b>  |   | 22c. DATE SIGNED<br><b>1/31/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Leonard Wallenstein</b>   |   | 22e. ADDRESS<br><b>711 W. 40th Street 21211</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>2/2/83</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cemetery Baltimore, Maryland</b> | 23d. LOCATION CITY OR TOWN COUNTY STATE  |
| 24. FUNERAL DIRECTOR NAME<br><b>Burgess Funeral Home, 3631 Falls Road 21211</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 1 1983</b>                                      |  |

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MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

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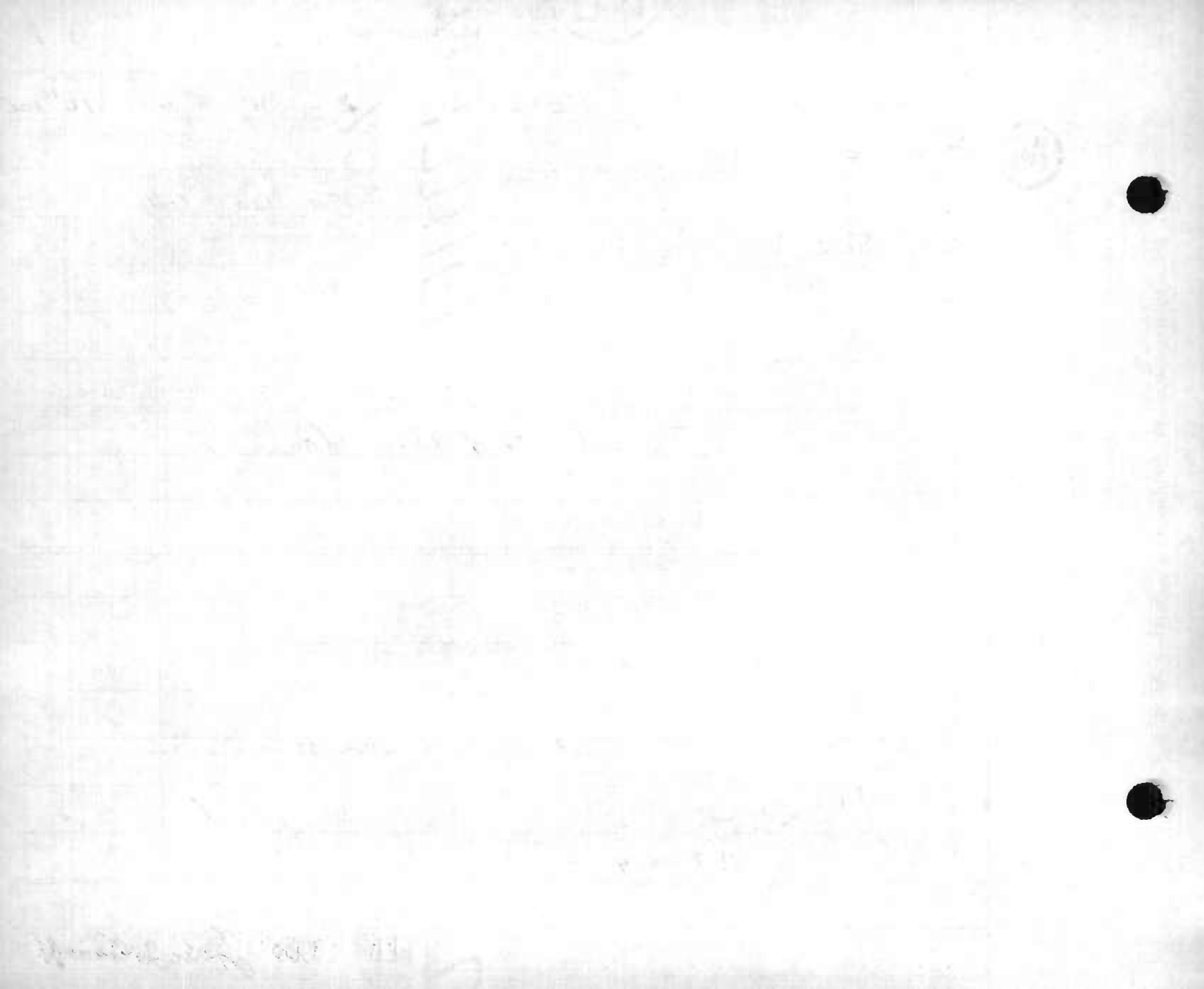
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1539.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   |   |   |  |  |   | 83 01107<br>REG. NO.   |  |                                       |  |  |  |   |  |
|--|--|--|---|---|---|---|--|--|---|--|--|---------------------------------------|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |   |   |   |   |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR   |  |                                       |  | 2b. HOUR   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Estelle M. KESLER</i>   |  |  |   |   |   |   |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>2-30-83</i>   |  |                                       |  | 2b. HOUR<br><i>10:10 PM</i>  |  |   |  |
| 3. SEX<br><i>Female</i>  |  |  | 4. RACE<br><i>Black</i>   |   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>9 18 23</i>   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><i>59 YRS</i> |  |  | IF UNDER 1 YEAR<br>IF UNDER 24 HRS    |  |  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>N. Carolina</i>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore city</i> MD        |  |  |                                       |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Provident Hospital</i> |   |   |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)           |  |  | 12b. KIND OF BUSINESS OR INDUSTRY     |  |  |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Maryland</i>   |  |  |   |   |   |   |  |  |   | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><i>Baltimore</i> |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>2632 Beryl Avenue 21205</i> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Robert Cofield</i>   |  |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Estelle Wilson</i> |   |  |  |   |  |  |                                       |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>No</i>   |  |  |   |   | 16b. SOCIAL SECURITY NO.<br><i>N/A</i>                              |   | 17. INFORMANT ADDRESS<br><i>Jimmie C. Kesler 2632 Beryl Avenue</i> |  |   |  |  |                                       |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY<br><i>1539</i> IMMEDIATE CAUSE (a) <i>Terminal Co of the colon.</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |  |   |   |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                                       |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |   |   |   |   |  |  |   |  |  |                                       |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                    |  |                                       |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>      |   |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |  |                                       |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |  |  |                                       |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12-28-83</i> , 19 <i>Jan 30, 83</i> , that (I) (we) last saw the deceased alive on <i>above</i> , (I) (we) (did) (did not) view the body after death, 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated                              |  |  |   |   |   |   |  |  |   |  |  |                                       |  |  |  |   |  |
| 22b. SIGNATURE<br><i>[Signature]</i>   |  |  |   |   |   |   |  | DEGREE   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><i>1-30-83</i>    |  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Harold Ramsey</i>  |  |  |   |   |   |   |  | 22e. ADDRESS   |   |  |  |                                       |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>BURIAL</i>   |  |  |   | 23b. DATE<br><i>2/4/83</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Western Star Cem.</i>  |  |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Baltimore Md.</i>  |  |                                       |  |  |  |   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><i>Wm. C. March F/H Inc. 1101 E. North Avenue</i>   |  |  |   |   |   |   |  | 25. DATE REC'D. BY REGISTRAR<br><i>FEB 1 1983</i>                              |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |                                       |  |  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   | 8 3 0 1 1 0 8                          |   |  |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   | REG. NO.   |   |  |   |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ALI SHER KHAN</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1 25 83</b> |   | 2b. HOUR<br><b>2<sup>00</sup> A.M.</b> |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>11 15 13</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>India</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>NO</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Professor</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Gov't of Pakistan</b>   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Howard</b>  |  | 13c. CITY OR TOWN<br><b>Ellicott City</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Ahmed Yar Khan</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>U N K N O W N</b>  |  | 13e. STREET ADDRESS<br><b>8313 Church Lane 21043</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218-90-2630</b>  |  | 17. INFORMANT ADDRESS<br><b>Ahsan Khan 8313 Church Lane 21043</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br><b>5850 IMMEDIATE CAUSE (a) Cardiorespiratory arrest.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>chronic renal failure.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/27/82</b> to <b>1/25/83</b> , that (I) (we) last saw the deceased alive on <b>1/27/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |
| 22b. SIGNATURE <b>R. Gonzalez</b> DEGREE  |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>1/25/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. GONZALEZ</b>   |  |   |  | 22e. ADDRESS<br><b>St. Agnes Hospital</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/27/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crestlawn Mem. Park</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Marriottsville Howard Md.</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Hubbard Funeral Home, Inc.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR (IN REGISTRAR'S SIGNATURE)<br><b>JAN 28 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. [Signature]</b>  |  |
| ADDRESS<br><b>4107 Wilkens Avenue</b>   |  |   |  |   |  |   |  |

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*[Faint, illegible handwritten notes]*

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |  |  |  |  |  | 8301109   |  |
|---|--|--|--|--|--|--|--|--|--|---|--|
| 1 - STATE REGISTRAR   |  |  |  |  |  |  |  |  |  | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Theodore A. Kiecal SR.</i>  |  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>Jan 17 1983</i>                           |  | 2b. HOUR<br><i>1:30 PM</i>   |  |   |  |
| 3 SEX<br><i>MALE</i>  |  | 4 RACE<br><i>WHITE</i>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>4 24 1916</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>66</i> YRS                                 |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN.              |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>MARYLAND</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTIMORE CITY MD.</i>                |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>BALTIMORE CITY</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>CITY HOSPITAL</i> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>FORKLIFT</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>AMERICAN CH</i>                |  |   |  |
| 13a. STATE<br><i>MARYLAND</i>   |  | 13b. COUNTY<br><i>BALTIMORE</i>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><i>811 S. GLOVER ST.</i>                                  |  |  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>ANDREW KIECAL</i>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>MARY LISEK</i>  |  |  |  | 21224  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE BRANCH AND DATE)<br><i>NO</i>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><i>217-094122</i>  |  | 17. INFORMANT ADDRESS<br><i>CECILIA KIECAL 811 S. GLOVER ST.</i>                 |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br><i>4275 IMMEDIATE CAUSE (a) Cardiac pulmonary arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>Pseudomonas pneumonia; Chronic aspiration</i>  |  |  |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/4/83</i> , 19 <i>83</i> , to <i>1/17/83</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>1/17</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Bruce Kinosian</i>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  |  |  | 22c. DATE SIGNED<br><i>1/17/83</i>                                     |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Bruce Kinosian</i>  |  |  |  |  |  | 22e. ADDRESS   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><i>BURIAL</i>  |  |  |  | 23b. DATE<br><i>1/21/83</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>ST. STANISLAUS</i>                      |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>BALTIMORE MD.</i>        |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br><i>RAYMOND H. KACZOROWSKI</i>  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 19 1983</i>                              |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Conner</i>                    |  |   |  |





OFFICE OF THE  
DIRECTOR  
OF THE  
BUREAU OF  
LANDS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| FOR STATE REGISTRAR  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |   | 8 3 0 1 1 1 0              |  |
|--|--|--|---|----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)   |  | KATHERINE GENEVIEVE KILPATRICK   |   | REG. NO.                   |  |
| 2a. DATE OF DEATH  | MONTH DAY YEAR   | 2b. HOUR   |   |                            |  |
| 1  | 31 83  | 845 P.M.   |   |                            |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | IF UNDER 1 YEAR            |  |
| XXXX FEMALE  | CAUCASIAN  | 5 21 01  | 81  | MONTHS DAYS HOURS MIN.     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                            |  |
| MICHIGAN   | U.S.A.   |  | city MD.  |                            |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                            |  |
| Baltimore  | XXXXXXX S. BALTO. GEN. HOSP.   | HOMEMAKER  |   |                            |  |
| 13a. STATE   | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS        |  |
| MD   | BALTIMORE  | DUNDALK  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 7601 MEADOW WAY 21222      |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |   |                            |  |
| LOUIS H. KANITZ  | CATHERINE O'GRADY  | NO   |   |                            |  |
| 16b. SOCIAL SECURITY NO.   | 17. INFORMANT  | ADDRESS  |   |                            |  |
| 219-32-5502A   | MARY E. COURSEY (SAME AS 13E)  |  |   |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  |   |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 5860 IMMEDIATE CAUSE (a) Cardiopulmonary arrest  |  |  |   |                            |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) congestive heart failure  |  |  |   |                            |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) Renal Failure   |  |  |   |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |   |                            |  |
| Bilateral cerebral vascular accident   |  |  |   |                            |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                            |  |
|  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   | YES <input type="checkbox"/> NO <input type="checkbox"/>            |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |                            |  |
|  | P.M. 19  |  |   |                            |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |                            |  |
|  |  |  |   |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/16/83 to 1/31/83, that (II) (we) lost saw the deceased alive on 1/31/83, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |                            |  |
| 22b. SIGNATURE   | DEGREE   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                          |   | 22c. DATE SIGNED           |  |
| M. Nestor  | M.D.   |  |   | 1/31/83                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  | 22e. ADDRESS   |  |   |                            |  |
| Nestor   | 3001 S. Hanover St.  |  |   |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY   | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |                            |  |
| CREMATION  | 2-1-1983   | GREEN MOUNT CREMATORY  | BALTIMORE CITY, MD  |                            |  |
| 24. FUNERAL DIRECTOR NAME  |  | 25a. DATE RECD. BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE |  |
| WALTER BROOKS BRADLEY, INC. BALTIMORE, MD  |  | FEB 4 1983   |   | John J. Conish             |  |

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Handwritten notes at the top of the page, including the word "Kuparuk" and other illegible scribbles.

Handwritten notes in the middle section, featuring several lines of cursive script.

Handwritten notes at the bottom of the page, including a circular stamp or diagram and more illegible text.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PH-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | REG. NO. 83 01111   |  |
|--|--|--|--|--|--|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR   |  |  |  |  |  |  |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>JAMES CHARLES KING</b>  |  |  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>1-25-83</b>  |  |
| 3 SEX 4 RACE 5. DATE OF BIRTH MONTH DAY YEAR 6. AGE (IN YEARS LAST BIRTHDAY) 7. IF UNDER 1 YR. 8. IF UNDER 24 HRS.<br><b>MALE WHITE 05 06 21 61 YRS.</b>   |  |  |  |  |  |  |  |  |  | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br><b>1-25-83</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 7b. CITIZEN OF WHAT COUNTRY? 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/><br><b>MARYLAND U.S.A.</b>  |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>   |  |
| 10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore Mercy Hospital</b>   |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HANDLER PRESS &amp; PAPER NEWSPAPER</b> |  |
| 13a. STATE 13b. CITY OR TOWN 13c. INSIDE CITY LIMITS? 13d. STREET ADDRESS<br><b>MARYLAND A.A. LINTHICUM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2 COLONIAL DRIVE, 21090</b>  |  |  |  |  |  |  |  |  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>JOSEPH KING</b>  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>MARY ADAMS</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS<br><b>YES WW II 220-14-1757 JAMES L. KING 2322 ARBUTON AVENUE, 21230</b>   |  |  |  |  |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY?<br><b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>  |  |  |  |  |  |  |  |  |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>Margareta A. Koroll</b> TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED <b>1-26-83</b>   |  |  |  |  |  |  |  |  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Koroll, M.D.</b> ADDRESS <b>111 Penn Street</b>  |  |  |  |  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BURIAL 01-29-83 GLEN HAVEN MEM. PK. GLEN BURNIE A.A. MARYLAND</b>   |  |  |  |  |  |  |  |  |  |   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229 JAN 28 1983 [Signature]</b>  |  |  |  |  |  |  |  |  |  |   |  |

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COMMITTEES

WINDWARD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

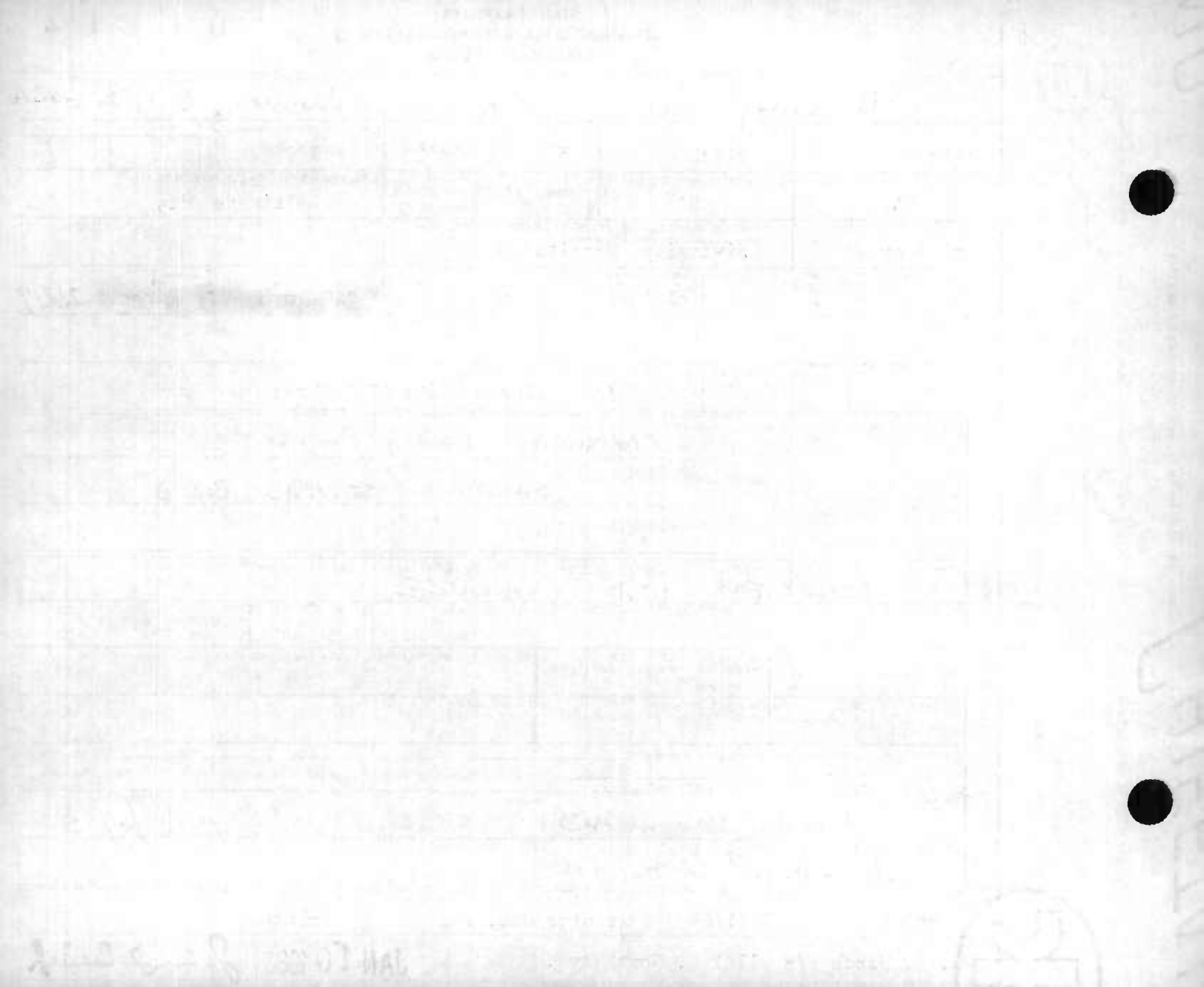
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 1 2

REG. NO.

|   |   |  |   |  |  |
|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIAM W. KING</b>  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>January 6 1982</b> 2b. HOUR <b>8:48A</b>                            |  |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Black</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>5 12 1882</b>  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>100</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VA</b>   | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                       |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY            |
| 13a. STATE<br><b>MD</b>   | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>         | 13e. STREET ADDRESS<br><b>727 Druid Lake Park Dr. 21217</b>                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>   |   | 17. INFORMANT ADDRESS<br><b>Susan White 4706 Three Oaks Road</b>               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOVASCULAR COLLAPSE</b><br>5789<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>GASTROINTESTINAL BLEED.</b><br>(c)      |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>CONGESTIVE HEART FAILURE</b>   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Julie Ann P. Casani MD</b>   |   |  |   | 22c. DATE SIGNED<br><b>1/6/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JULIE ANN P. CASANI, MD</b>   |   |  |   | 22e. ADDRESS   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |   | 23b. DATE<br><b>1/11/83</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>                  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus MD</b>   |   | 25a. DATE RECD. BY REGISTRAR<br><b>JAN 10 1983</b>   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E. North Ave.</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Casani</b>  |   |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove co-bonifiers, Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |  |                       |  |  |
|--|--|---|--|---|---|--|-----------------------|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   | REG. NO.  |  |                       |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>DIXIE LANCASTER KIRBY   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>01 28 83   |  | 2b. HOUR<br>2:00 P.M. |  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>CAUCASION  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JULY 27 1919  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS.   |                       | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NEW JERSEY  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |                       |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>THE JOHNS HOPKINS HOSPITAL |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SECRETARY           |                       | 12b. KIND OF BUSINESS OR INDUSTRY<br>ANTIOCH COLLEGE   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                       |  |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY<br>HOWARD   |  | 13c. CITY OR TOWN<br>COLUMBIA   |   | 13e. STREET ADDRESS<br>6513 QUIET HOURS APT T-1                                      |                       |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOHN DUFFY   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>EMMA JOHNSON   |   |  |                       |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO N/A   |  |   |  | 16b. SOCIAL SECURITY NO.<br>148-07-6544   |   | 17. INFORMANT<br>ADDRESS<br>COLUMBIA, MD 21044<br>KAREN SMITH 5043 WHETSTONE RD      |                       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>1830 IMMEDIATE CAUSE (a) Cardio-pulmonary arrest<br>(b) metastatic adenocarcinoma<br>(c) of probably the ovaries<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT BELONGING TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br>possible metastasis to brain. |  |   |  |   |   |  |                       |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                      |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |                       |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |                       |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/20 19 83, to 1/28 19 83, that (I) (we) last saw the deceased alive on 1/28 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |  |                       |  |  |
| 22b. SIGNATURE<br>Morris D. Albuerne   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br>1/28/83  |                       |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Morris D. Albuerne  |  |   |  | 22e. ADDRESS<br>VINELAND N.J.   |   |  |                       |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>1/31/83  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>SILOAM CEMT.  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>VINELAND CUMBERLAND N.J.               |                       |  |  |
| 24. FUNERAL DIRECTOR (CLASSAN F.H.)<br>NAME ADDRESS<br>PAWCOAST F.H. 676 S. MAIN   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 5 1983   |   |  |                       |  |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Pina  |   |  |                       |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 01114

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |  |   |  |  |  |  |  |
|---|--|--|--|---|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST <u>Rose</u> MIDDLE <u>Kitt</u> LAST <u>Kitt</u>  |  |  | 2a. DATE OF DEATH<br>MONTH <u>01</u> DAY <u>15</u> YEAR <u>83</u>      |   |  | 2b. HOUR<br><u>1:55</u> A.M.   |   |  |  |  |  |  |
| 3. SEX<br><u>Female</u>   |  | 4. RACE<br><u>Caucasian</u>  |  | 5. DATE OF BIRTH<br>MONTH <u>04</u> DAY <u>21</u> YEAR <u>1897</u>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>85</u> <u>84</u> YRS.                          |   | IF UNDER 1 YEAR<br>MONTHS <u>0</u> DAYS <u>0</u>                                   |  | IF UNDER 24 HRS.<br>HOURS <u>0</u> MIN. <u>0</u> |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><u>RUSSIA</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore City</u> MD.                    |   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><u>Baltimore, MD</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Sinai Hospital</u> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>HOUSEWIFE</u> |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>AT HOME</u>  |  |  |  |
| 13a. STATE<br><u>MD</u>   |  |  | 13b. COUNTY<br><u>Baltimore</u>  |   | 13c. CITY OR TOWN<br><u>Baltimore</u>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><u>6930 Glen Heights Rd #21215</u>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST <u>JOSEPH</u> MIDDLE <u>GOLDFEIN</u> LAST <u>GITTEL</u>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <u>GITTEL</u> MIDDLE <u>UNKNOWN</u> LAST <u>UNKNOWN</u>  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>NO</u>   |  |  | 16b. SOCIAL SECURITY NO.<br><u>216-09-9602</u>                         |   | 17. INFORMANT <u>MRS. ESTELLE GERSUK</u><br><u>4120 FALLSTAFF RD. #21215</u>   |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><u>5850</u> IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Chronic renal failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |  |  |  |  |
| 22a. I certify that (if this hospital) attended the deceased from <u>12/18</u> , 19 <u>82</u> , to <u>1/15</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>1/15</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                  |  |  |  |   |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Deborah Ward</u> MD  |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  |  | 22c. DATE SIGNED<br><u>1/15/83</u>               |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Deborah Ward</u>  |  |  |  |   | 22e. ADDRESS<br><u>Sinai Hospital of Baltimore</u>   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>BURIAL</u>  |  |  | 23b. DATE<br><u>1-16-83</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>BOBROISKER BENEFICIAL CIRCLE LODGE</u>  |  |   | 23d. LOCATION<br>CITY OR TOWN <u>ROSEDALE</u> COUNTY <u>BALTO.</u> STATE <u>MD</u> |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <u>SOL LEVINSON &amp; BROS., INC.</u> ADDRESS <u>6010 REISTERSTOWN RD., BALTO., MD 21215</u>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>JAN 18 1983</u>                                  |   | 25b. REGISTRAR'S SIGNATURE<br><u>J. J. Carney</u>                                  |  |  |  |  |

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 3 0 1 1 1 5<br>REG. NO.  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Hendrietta Klein</i>  |  |  |  | 2b. DATE OF DEATH MONTH DAY YEAR<br><i>1 31 83</i>   |  |  |  |
| 3. SEX <i>F</i>  |  |  |  | 4. RACE <i>Cauc.</i>   |  |  |  |
| 5. DATE OF BIRTH MONTH DAY YEAR<br><i>10 5 95</i>  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><i>8 7</i> YRS.  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>   |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>  |  |  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Balto City MD.</i>  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Balto.</i>   |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Armcast Bsg. Home.</i> |  |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i>  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Homemaking</i>   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN<br><i>Md. Balto Lutherville</i>  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                     |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Valentine Hoffman</i>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Helena Umlout</i>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 16b. SOCIAL SECURITY NO.<br><i>No. 217-60-3819</i>   |  |  |  | 17. INFORMANT ADDRESS<br><i>Geo. A. Klein 107 Greenridge Rd. J. Barrett R.D. - Armcast 21093</i>                                 |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br><i>4292 IMMEDIATE CAUSE (a) ASCVD - Senility CBS.</i>   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>10 yr</i>   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><i>(b) Cardiac Arrest</i>  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF<br><i>Arrest</i>  |  |  |  |
|  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF<br><i>(c)</i>   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><i>11</i>  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>PM 19</i>   |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK                           |  |  |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>9-29</i> , 19 <i>77</i> , to <i>1-31</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>1/31</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>B. Maurice Feldman MD</i>   |  |  |  | 22c. DATE SIGNED   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>DR. Maurice Feldman</i>  |  |  |  | 22e. ADDRESS<br><i>6610 CrossCountry Blvd.</i>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  |  |  | 23b. DATE<br><i>1-31-83</i>  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><i>Parkwood Cemetery</i>   |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Baltimore, Maryland</i>  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><i>Lassahn</i>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR (BY REGISTRAR'S SIGNATURE)<br><i>21236 FEB 3 1983 John J. Conner</i>                               |  |  |  |
| 25b. ADDRESS<br><i>7401 Belair Rd.</i>   |  |  |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 1/81  
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal case must be filed in the coroner's office.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 3 0 1 1 1 6   |  |  |  |
|--|--|--|--|---|--|--|--|
| FOR<br>1. STATE<br>REGISTRAR   |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (FIRST, MIDDLE, LAST)<br><b>James H. Klinefelter</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>January 8, 1983</b>  |  | 2b. HOUR<br><b>M</b>   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Nov. 10, 1911</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br><b>71</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>               |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Manufact. Rep</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Service Equip. Stations</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS?<br><b>Md - Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>  |  |  |  | 13e. STREET ADDRESS<br><b>1206 W. 40th Street 21211</b>   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>James Grant Klinefelter</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Rosa T. Schmaing</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212 07 4107</b>   |  | 17. INFORMANT ADDRESS<br><b>Arnetta Klinefelter same</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4140 Cardiac arrhythmia.</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Barlow's Syndrome</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Atherosclerotic Heart Disease</b>   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>immediate</b><br><b>Many years</b><br><b>Many years</b>                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a<br><b>congestive Heart Failure</b>   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) <u>the hospital</u> attended the deceased from <u>11-25</u> 19 <u>81</u> , to <u>1-9</u> 19 <u>82</u> , that (I) <u>did not</u> last saw the deceased alive on <u>12-21</u> 19 <u>82</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Warren Israel</b>   |  |  |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1-10-83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Warren Israel</b>  |  |  |  | 22e. ADDRESS<br><b>Ruxton Towers Apartments</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/12/83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Pikesville Balto. Co. Md.</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Burgee Funeral Home</b>  |  |  |  | ADDRESS<br><b>3631 Falls Road 21211</b>   |  | DATE REC'D. BY REGISTRAR 25. REGISTRAR'S SIGNATURE<br><b>JAN 11 1983</b>   |  |





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem examinations must be completed at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |                          |  |   |   |                     |  |  |
|--|--|--|--|--|--------------------------|--|---|---|---------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |  |  | 2a. DATE OF DEATH        |  |   |   |                     | 2b. HOUR   |  |
| MARGARET S. KLINGELHOFFER  |  |  |  |  | 01 15 83                 |  |   |   |                     | 12:10 P.M.   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |                          | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | 7. IF UNDER 1 YEAR  |                     | 7. IF UNDER 24 HRS.  |  |
| Female   |  | White  |  | Nov. 15, 1898  |                          | 84 YRS.  |   | MONTHS DAYS   |                     | HOURS MIN.   |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                          | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |   |                     |  |  |
| PA   |  | USA  |  |  |                          | BALTIMORE CITY MD.   |   |   |                     |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |   | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                     |  |  |
| BALTO  |  | UNION MEMORIAL HOSPITAL  |  |  |                          | Homemaker  |   | Own Home  |                     |  |  |
| 13a. STATE   |  |  |  |  | 13b. CITY OR TOWN        |  | 13c. INSIDE CITY LIMITS?  |   | 13d. STREET ADDRESS |  |  |
| Maryland   |  |  |  |  | Talbot                   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | Royal Oak, MD 21662 |  |  |
| 14. FATHER'S NAME  |  |  |  |  | 15. MOTHER'S MAIDEN NAME |  |   |   |                     |  |  |
| James M. Stoner  |  |  |  |  | Gertrude Courtney        |  |   |   |                     |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  |  | 16b. SOCIAL SECURITY NO. |  | 17. INFORMANT ADDRESS   |   |                     |  |  |
| No   |  |  |  |  |                          |  | Mrs. Charles S. Garland, Balto., MD                                 |   |                     |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  |  |  |                          |  |   |   |                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| 4960 IMMEDIATE CAUSE (a) COPD  |  |  |  |  |                          |  |   |   |                     |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)   |  |  |  |  |                          |  |   |   |                     |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |                          |  |   |   |                     |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |                          |  |   |   |                     |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |                          |  |   |   |                     |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                          |  |   | 20a. AUTOPSY?   |                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  |  |                          |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                     | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY  |                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) |   |   |                     |  |  |
|  |  |  |  | HOUR A.M. MONTH DAY YEAR   |                          |  |   |   |                     |  |  |
| 21d. INJURY OCCURRED   |  |  |  | 21e. PLACE OF INJURY   |                          | 21f. LOCATION  |   |   |                     |  |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  |  | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]   |                          | STREET CITY OR TOWN COUNTY STATE   |   |   |                     |  |  |
| 22a. I certify that (this hospital) attended the deceased from 1/2, 19 83, to 1/15, 19 83, that (we) lost saw the deceased alive on 1/15, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death. |  |  |  |  |                          |  |   |   |                     |  |  |
| 22b. SIGNATURE   |  |  |  | DEGREE   |                          |  |   | 22c. DATE SIGNED  |                     |  |  |
| Dr. Brian H. Kahn, M.D.  |  |  |  |  |                          |  |   | 1/15/83   |                     |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |                          |  |   |   |                     |  |  |
| Dr. Brian H. Kahn, M. D.   |  |  |  | Union Memorial Hospital, Balto., MD  |                          |  |   |   |                     |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                          | 23d. LOCATION  |   | 23e. DATE REC'D. BY REGISTRAR                                       |                     |  |  |
| Cremation  |  | 1/17/83  |  | Green Mount  |                          | Balto., MD   |   | 1/17/1983   |                     |  |  |
| 24. FUNERAL DIRECTOR   |  | NAME   |  | ADDRESS  |                          | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE  |                     |  |  |
| Henry W. Jenkins & Sons Co.  |  | 4905 York Road Balto., MD 21212  |  |  |                          | IAN 171983   |   | John J. Connel  |                     |  |  |

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Form 1

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Nov. 1, 1960

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FOR WORKING

For attention of John F. Kennedy

Mr. J. F. Kennedy, President of the United States, Washington, D.C.

Dear Mr. President:

I am writing to you today to express my appreciation for the many ways in which you have helped to improve the lives of the people of the United States.

Sincerely,  
John F. Kennedy

John F. Kennedy

John F. Kennedy, President of the United States, Washington, D.C.

Charles W. Johnson, Jr., President of the Charles W. Johnson & Co.

Charles W. Johnson & Co., 1000 North 17th Street, New York, N.Y.

Charles W. Johnson & Co., 1000 North 17th Street, New York, N.Y.

STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8 3 0 1 1 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |  |   |  |   |  |
|---|--|--|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>KATHERINE R. KINNIER   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>January 17, 1983                   |   |  | 2b. HOUR<br>9:05 PM.   |   |  |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 16, 1903   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Long Green Nursing Home |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Comptometer Operator                     |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Fed. Govt.  |   |  |
| 13a. STATE<br>Maryland  |  |  | 13b. CITY OR TOWN<br>21218   |   | 13c. CITY OR TOWN<br>Baltimore                             |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Robert Kinnier  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Marie Piez       |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No ----- |   |  | 16b. SOCIAL SECURITY NO.<br>217-16-6015 |  |
| 17. INFORMANT<br>ADDRESS<br>Sarah Medinger 3708 Loch Raven Blvd. 21218  |  |  |  |   |  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4292 CLSC VD<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>C.V.A. - Decubitus ulcers legs |  |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                    |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)                               |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the decedent from 1-18-83 to 1-17-83, that (I) (we) lost saw the decedent alive on 1-18-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If the family did not view the body after death, so state.)  |  |  |  |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br>W. G. Helfrich MD   |  |  |  |   |  | DEGREE<br>MD   |   | 22c. DATE SIGNED<br>1-19-83  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>William G. Helfrich M.D.   |  |  |  |   |  | 22e. ADDRESS<br>5006 Roland Avenue 323-4333  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  | 23b. DATE<br>Jan. 21, 1983   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge Cemetery |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore County, Maryland                        |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>William E. Johnson 8521 Loch Raven Blvd.  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 19 1983   |   | 25b. REGISTRAR'S SIGNATURE<br>John J. Canfield   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8301119

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ORVILLE K. KNAVENSHU   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 28 83  |  | 2b. HOUR<br>4:00A M   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan. 17, 1931   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>52 YRS.  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>West Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VAMC LOCH RAVEN BLVD. BALTO MD |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Laborer   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Steel  |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>W. Virginia   |  | 13b. COUNTY<br>Randolph   |  | 13c. CITY OR TOWN<br>Elkins   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Kent Knavenshu   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Olive Boggs  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes Korean  |  | 16b. SOCIAL SECURITY NO.<br>234 46 4770   |  |
| 17. INFORMANT<br>ADDRESS<br>Carolyn Kimmelman 8185 Telegraph Rd.   |  | 17. INFORMANT<br>ADDRESS<br>Severn, Md. 21144   |  | 17. INFORMANT<br>ADDRESS<br>Severn, Md. 21144   |  | 17. INFORMANT<br>ADDRESS<br>Severn, Md. 21144   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>1629 IMMEDIATE CAUSE (a) MASSIVE HEMOPTYSIS   |  | DUE TO, OR AS A CONSEQUENCE OF<br>(b) LUNG CANCER   |  | DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>10 MINUTES<br>2 YEARS  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 31, 1982, to January 28, 1983, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on January 28, 1983, and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>A. Kurland MD  |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br>1/28/83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>D. KURLAND MD   |  | 22e. ADDRESS<br>3900 Loch Raven Baltimore, Maryland 21218   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>1/31/1983  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>I.O.O.F. Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Elkins, Randolph, W. Virginia   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>McCutty Funeral Home of Pasadena   |  | 24. FUNERAL DIRECTOR<br>ADDRESS<br>21122  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 2 1983   |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Conner  |  |

BP



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Handwritten text, mostly illegible due to fading and bleed-through. Some words like "RECEIVED" and "MAY 1944" are faintly visible.



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 2. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOUR FILES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |         |                  |   |                   |                     |   |  |  |   |  |  |                                       |  |  |
|--|---------|------------------|---|-------------------|---------------------|---|--|--|---|--|--|---------------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         |                  | 2a. DATE KNOWN OF DEATH                                     |                   |                     | 2b. DATE OF DEATH   |  |  | 2c. DATE PRONOUNCED DEAD  |  |  | 2d. DATE OF DEATH                     |  |  |
| Sun Shick Koh  |         |                  | 1 19 19 83  |                   |                     | 1 19 19 83  |  |  | 1 19 19 83  |  |  | 10:39 P M                             |  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS)   | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS. | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  | 10. BALTIMORE CITY OR COUNTY OF DEATH                               |  |  | 11. BALTIMORE CITY OR COUNTY OF DEATH |  |  |
| Male   | Korean  | March 10, 1941   | 41 YRS.   |                   |                     | Baltimore City  |  |  | Baltimore City  |  |  | Baltimore City                        |  |  |
| 12. CITY OR TOWN OF DEATH  |         |                  | 13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |                   |                     | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  |  | 15. KIND OF BUSINESS OR INDUSTRY                                    |  |  | 16. BALTIMORE CITY OR COUNTY OF DEATH |  |  |
| Baltimore  |         |                  | University Hospital, Shock Trauma                           |                   |                     | Foreman - Painting Co.  |  |  |   |  |  | Baltimore City                        |  |  |
| 17. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |         |                  | 18. CITY OR TOWN  |                   |                     | 19. INSIDE CITY LIMITS?   |  |  | 20. STREET ADDRESS  |  |  | 21. BALTIMORE CITY OR COUNTY OF DEATH |  |  |
| Maryland   |         |                  | Baltimore   |                   |                     | Essex   |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 8909 Gordon Tree Lane, 21221          |  |  |
| 22. FATHER'S NAME  |         |                  | 23. MOTHER'S MAIDEN NAME                                    |                   |                     | 24. WAS DECEASED EVER IN U.S. ARMED FORCES?                                   |  |  | 25. SOCIAL SECURITY NO.   |  |  | 26. INFORMANT ADDRESS                 |  |  |
| Nam Joon Koh   |         |                  | So Kim Soon   |                   |                     | No  |  |  | 218-76-2540   |  |  | Jung Ja Koh, same as #13e             |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |                  |   |                   |                     |   |  |  |   |  |  |                                       |  |  |
| PART I DEATH WAS CAUSED BY: Multiple Injuries  |         |                  |   |                   |                     |   |  |  |   |  |  |                                       |  |  |
| 8147 IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF  |         |                  |   |                   |                     |   |  |  |   |  |  |                                       |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |         |                  |   |                   |                     |   |  |  |   |  |  |                                       |  |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |         |                  |   |                   |                     |   |  |  |   |  |  |                                       |  |  |
| (c)  |         |                  |   |                   |                     |   |  |  |   |  |  |                                       |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |                  |   |                   |                     |   |  |  |   |  |  |                                       |  |  |
| 19a. DATE OF OPERATION   |         |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                   |                     |   |  |  | 20. AUTOPSY?  |  |  |                                       |  |  |
|  |         |                  |   |                   |                     |   |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |                                       |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |                  | 21b. TIME OF INJURY   |                   |                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |   |  |  |                                       |  |  |
|  |         |                  | 9:28 M. 1 19 83   |                   |                     | pedestrian struck by automobile   |  |  |   |  |  |                                       |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |         |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                   |                     | 21f. LOCATION   |  |  |   |  |  |                                       |  |  |
|  |         |                  | road  |                   |                     | Rt. 40 near Middle River Rd., Essex, Md.                                      |  |  |   |  |  |                                       |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |         |                  |   |                   |                     |   |  |  |   |  |  |                                       |  |  |
| ACTUAL SIGNATURE   |         |                  | TITLE (SPECIFY)   |                   |                     |   |  |  | DATE SIGNED   |  |  |                                       |  |  |
| Hormez R. Guard, M.D.  |         |                  | M.D. Assistant  |                   |                     |   |  |  | 1/20/83   |  |  |                                       |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |                  | ADDRESS   |                   |                     |   |  |  | BALTIMORE CITY OR COUNTY OF DEATH                                   |  |  |                                       |  |  |
| Hormez R. Guard, M.D.  |         |                  | 111 Penn St., Balto, Md.                                    |                   |                     |   |  |  | Baltimore, Maryland   |  |  |                                       |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         |                  | 23b. DATE   |                   |                     | 23c. NAME OF CEMETERY OR CREMATORY  |  |  | 23d. LOCATION   |  |  |                                       |  |  |
| Burial   |         |                  | 1-22-83   |                   |                     | Dulaney Valley Cemetery   |  |  | Baltimore, Maryland   |  |  |                                       |  |  |
| 24. FUNERAL DIRECTOR NAME  |         |                  | ADDRESS   |                   |                     | 25. DATE REC'D. BY REGISTRAR  |  |  | REGISTRAR'S SIGNATURE   |  |  |                                       |  |  |
| Ruck Towson Funeral Home, Inc.   |         |                  | 1050 York Rd. Towson, Md. 21204                             |                   |                     | JAN 24 1983   |  |  | John J. Connel  |  |  |                                       |  |  |



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8301121

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |   |   |                              |  |  |
|---|--|---|---|---|------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>Joseph M. Kolibaba</i>            |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>1-24-83</i> |   | 2b. HOUR<br><i>4:26 P.M.</i> |  |  |
| 3. SEX<br><i>Male</i>   |  | 4. RACE<br><i>White</i>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>3-4-32</i>   |                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>50</i> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Pennsylvania</i>            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>United States</i>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                              |  |
| 10. CITY OR TOWN OF DEATH<br><i>Balt.</i>                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Mercy Hosp.</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>NONE</i>   |                              | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><i>Maryland</i>   |  | 13b. COUNTY<br><i>-</i>   |   | 13c. CITY OR TOWN<br><i>Baltimore</i>   |                              | 14. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>John G. Kolibaba</i>           |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Helen - Matto</i>   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>NO</i>   |                              | 16b. SOCIAL SECURITY NO.<br><i>195-10-8131</i>   |  |
| 17. INFORMANT<br>ADDRESS<br><i>Mary Halloran / 1514 Doxbury Rd. (21204)</i> |  |   |   |   |                              |  |  |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Bacterial Sepsis</i><br><i>5990</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Urinary tract infection</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
|--|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  
*Mental Retardation / Seizure Disorder*

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                               |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>11:20</i> P.M. <i>19</i> |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)         |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><i>1/24</i> <i>83</i> <i>1/24</i> <i>83</i>   |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>1/24</i> <i>83</i> to <i>1/24</i> <i>83</i> , that (1) (we) lost<br>saw the deceased alive on <i>1/24</i> <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (1) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Kenneth Kung</i>   |  | DEGREE<br><i>MD</i>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>1/24/83</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Kenneth Kung</i>  |  | 22e. ADDRESS<br><i>Mercy Hosp.</i>   |  |  |  |   |  |

|  |  |                                   |  |   |  |   |  |
|--|--|-----------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>                              |  | 23b. DATE<br><i>Jan. 26, 1983</i> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Sacred Heart Jesus</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>- - Baltimore Co., Md.</i> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Lilly &amp; Zeiler Inc. 700 S. Conkling St.</i> |  |                                   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 26 1983</i>             |  |   |  |
|  |  |                                   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Connel</i>             |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Little & Keller Inc. 100 E. Condit Ave.

88952 PAC

Jan. 25, 1967

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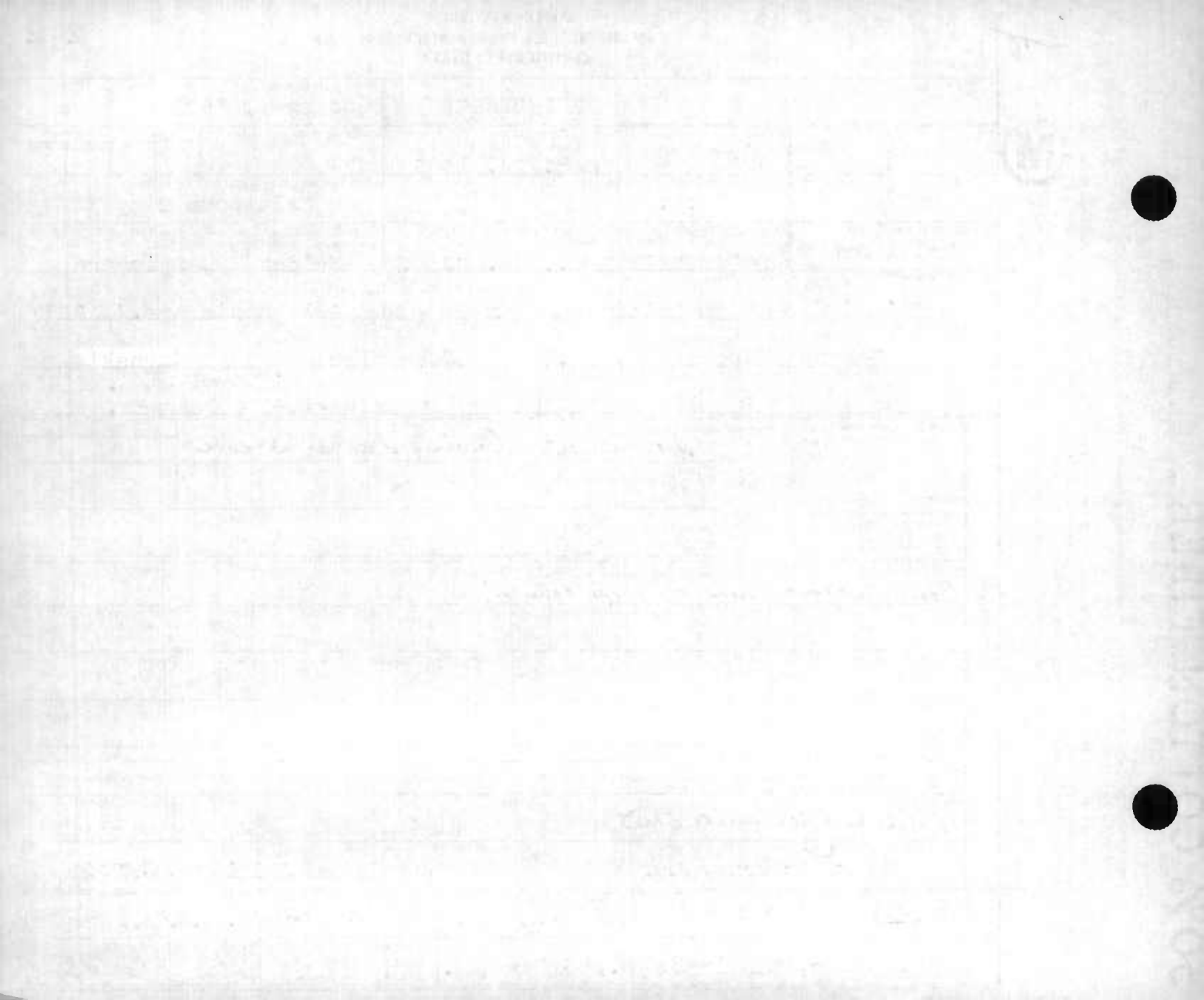
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 390-1113.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |                            |   |  |   |   |   |   | 8301122  |   |  |  |
|--|--|--|----------------------------|---|--|---|---|---|---|--|---|--|--|
| FOR<br>1. STATE<br>REGISTRAR   |  | REG. NO.   |                            |   |  |   |   |   |   |  |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>STEVE KOPCHINSKI</b>  |  |  |                            |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>January 4, 1983</b>   |   |   |   | 2b. HOUR<br>M   |  |   |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |                            | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 24, 1905</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.                                 |   | IF UNDER 1 YEAR<br>MONTHS DAYS  |   | IF UNDER 24 HRS<br>HOURS MIN.  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Poland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |                            | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                 |   |   |   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SOUTH BALTIMORE GEN. HOSP.</b> |                            |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Welder</b> |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Shipyard</b>  |  |   |  |  |
| 13a. STATE<br><b>Md.</b>   |  |  |                            |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>4218 Doris Ave. (21225)</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Kopchinski, Sr.</b>  |  |  |                            |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Josephine Wydazynski</b>   |   |   |   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |  |                            |   | 16b. SOCIAL SECURITY NO.<br><b>179 10 2322</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Larry Kopchinski, 8278 Abeam Dr. Millersville, Md. 21108</b> |   |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Coronary Vascular Disease</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |                            |   |  |   |   |   |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)<br><b>Coronary Heart Failure, Hypertension;</b>   |  |  |                            |   |  |   |   |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  |                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>           |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |                            | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)    |   |   |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |                            | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                 |   |   |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |                            |   |  |   |   |   |   |  |   |  |  |
| 22b. SIGNATURE<br><i>Michael Schwartz</i>  |  |  |                            |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   |   |   | 22c. DATE SIGNED<br><b>1/5/1982</b>  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Michael Schwartz, M.D.</b>   |  |  |                            |   | 22e. ADDRESS<br><b>606 Hammonds Lane, Baltimore, Md. 21225</b>   |   |   |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>1/7/82</b> |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Park</b>  |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie, A.A.Co., Maryland</b> |   |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>George J. Gonce, 4001 Ritchie Hg., Baltimore, Md.</b>   |  |  |                            |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 6 1983</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Connel</i>   |   |   |  |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  | 8301123                        |  |
|---|--|---|--|---|--|--|--|--|--|--------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |   |  |  |  |  |  |                                |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>Valentini  |  | MIDDLE<br>N.  |  | LAST<br>Kosmides   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 7, 1983   |  | 2b. HOUR<br>M                  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Mar. 29, 1892   |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>90  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Greece   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>City MD.                                     |  |  |  |                                |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF IN STATE, GIVE STREET ADDRESS)<br>5501 Hamlet Avenue |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife        |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                                |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>5501 Hamlet Avenue 21214  |  |                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Saraf  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Katherine Daskalakis   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>220-44-4325  |  | 17. INFORMANT ADDRESS<br>Mrs. Fevronia Petite Same   |  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma - of Bowel</u><br><u>1590</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |   |  |   |  |  |  |  |  |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Severe ASVD ? Heart failure</u>  |  |   |  |   |  |  |  |  |  |                                |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |                                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/15</u> 19 <u>82</u> to <u>1/7</u> 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>1/7</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                        |  |   |  |   |  |  |  |  |  |                                |  |
| 22b. SIGNATURE<br><u>Benjamin K. Yorkoff - MD</u>   |  | DEGREE  |  | 22c. DATE SIGNED<br><u>1/7/83</u>   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Benjamin Yorkoff MD  |  | 22e. ADDRESS<br>St. Joseph Professional Bldg  |  |   |  | Towson, Md. Rm 210   |  |  |  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>Jan. 10, 1983  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Greek Ortho. Cem.   |  | 23d. LOCATION<br>Towson Balto. COUNTY Md. STATE                                      |  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Smith</u>   |  |                                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck Inc. Baltimore, Maryland  |  | ADDRESS   |  | 25a. DATE RECEIVED BY REGISTRAR<br>JAN 10 1983  |  | 25c. REGISTRAR'S SIGNATURE   |  |  |  |                                |  |

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Handwritten notes and signatures on lined paper, including a large signature at the bottom and a circular stamp.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 1 2 4

FOR  
1. STATE  
REGISTRAR

REG. NO.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Madeline Ina Koterwas</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 9 83</b>                                    |  | 2b. HOUR<br><b>4:15 a.m.</b>   |
| 3. SEX<br><b>female</b>   | 4. RACE<br><b>white</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 6 29</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>53</b> YRS.                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St Agnes Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ex.Secretary</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Monumental</b>                         |  |
| 13a. STATE<br><b>MD</b>   |   |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Franklin K. Gilbert</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Edyth Jessop</b>                    |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>217-24-3269</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Frank Koterwas 3006 Illinois Ave.</b>           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1519</b> IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Metastatic Gastric Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I (this hospital) attended the deceased from <b>1/13</b> 19 <b>83</b> , to <b>1/9</b> 19 <b>82</b> , that (I) (we) lost saw the deceased active on <b>1/9</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.  |   |   |   |  |  |
| 22b. SIGNATURE<br><b>S. Hallick</b>   |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>1/9/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Galen Hallick</b>   |   | 22e. ADDRESS<br><b>St Agnes Hosp, Balt, Md.</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>1/11/83</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross Cem.</b>                   |  |
| 23d. LOCATION<br>CITY OR TOWN<br><b>A.A. Md.</b>  |   | 23e. COUNTY<br><b>A.A.</b>  |   | 23f. STATE<br><b>Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>George J. Gonce F.H. 4001 Ritchie Hgwy.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 10 1983</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                            |  |

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |   |   |  |  | 8 3 0 1 1 2 5                     |  |
|--|---|---|--|--|-----------------------------------|--|
| 1 - FOR<br>STATE<br>REGISTRAR  |   |   | CERTIFICATE OF DEATH   |  |                                   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   |   | 2a. DATE OF DEATH  |  |                                   | 2b. HOUR   |
| ALEXANDER JOSEPH KRISTAPONIS   |   |   | 1 29 83  |  |                                   | 0052 M   |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)                                  |  | IF UNDER 1 YEAR<br>MONTHS DAYS    |  |
| MALE   | WHITE   | 05 03 18  | 64 YRS.  |  | IF UNDER 24 HRS<br>HOURS MIN.     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                             |  |                                   |  |
| PENNSYLVANIA   | U.S.A.  |   | Baltimore City MD.   |  |                                   |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| BALTIMORE  | ST. AGNES HOSPITAL  |   | CHEMICAL ENG.  |  | F.M.C., INC.                      |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   |   | 13b. STREET ADDRESS  |  | 13c. CITY OR TOWN                 |  |
| MARYLAND   |   |   | 732 WARWICK ROAD, 21229  |  | KENSINGTON                        |  |
| 14. FATHER'S NAME  |   |   | 15. MOTHER'S MAIDEN NAME   |  |                                   |  |
| ZIGMAS   |   |   | PETRONELLA   |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |   |   | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT                     |  |
| NO   |   |   | 164-18-7066  |  | VERONICA A. KRISTAPONIS           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                  |  |                                   |  |
| 4100 IMMEDIATE CAUSE (a) Acute myocardial infarction   |   |   | 1 hr   |  |                                   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |   |   | (b) Atherosclerotic cardiovascular disease                       |  | years                             |  |
| (c) DUE TO, OR AS A CONSEQUENCE OF   |   |   |  |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |  |  |                                   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|  |   |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                   |  |
| 22a. I certify that I (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |   | 22b. SIGNATURE<br>DEGREE  |  | 22c. DATE SIGNED   |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   | 22e. ADDRESS  |  | 22f. REGISTRAR'S SIGNATURE   |                                   |  |
| Gregory F. McAniff, M.D.   |   | ST. AGNES HOSPITAL, 900 S. CATON AVENUE   |  | 1.29.83  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |   | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |                                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                     |
| BURIAL   |   | 02-01-83  |  | NEW CATHEDRAL  |                                   | BALTIMORE CITY MARYLAND  |
| 24. FUNERAL DIRECTOR<br>NAME   |   | 24b. ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR  |                                   | 25b. REGISTRAR'S SIGNATURE                                     |
| HUBBARD FUNERAL HOME, INC.   |   | 4107 WILKENS AVE.   |  | JAN 31 1983  |                                   | John J. Connel   |

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RECEIVED  
JAN 10 1964  
U.S. AIR FORCE  
HONOLULU, HAWAII

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RECEIVED  
JAN 10 1964  
U.S. AIR FORCE  
HONOLULU, HAWAII

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 1 2 6

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |   |                                   |  |
|---|--|---|---|--|---|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Elizabeth B. Kurland</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1 11 83</b>  |  |   | 2b. HOUR <b>1 P.</b> MIN <b>M</b> |  |
| 3. SEX<br><b>F</b> EMALE  | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>04 15 10</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. <b>BALTIMORE CITY</b> OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                        |  |   |                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balt.</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>                                       |                                   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. COUNTY <b>Balt.</b> 13c. CITY OR TOWN <b>Randallstown</b> |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>8824 Sigrid Road</b> 21133                                      |                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOSEPH BROWN</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br><b>TOBY MALINSKY</b>                                |  |   |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  |   | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><b>LOUIS J. KURLAND</b><br><b>8824 SIGRID RD. RANDALLSTOWN, MD 21133</b> |                                   |  |

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiac Arrhythmia**5570  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Infarcted Bowel**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

## MEDICAL CERTIFICATION

|  |   |  |  |
|--|---|--|--|
| 19a. DATE OF OPERATION<br><b>1/10/82</b>   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Abdominal pain</b>   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/11</b> , 19 <b>83</b> , to <b>1/11</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1/11</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |  |  |
| 22b. SIGNATURE<br><b>Suskin</b>  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br><b>1/11/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Suskin</b>   |   | 22e. ADDRESS<br><b>Sinai Hospital</b>  |  |

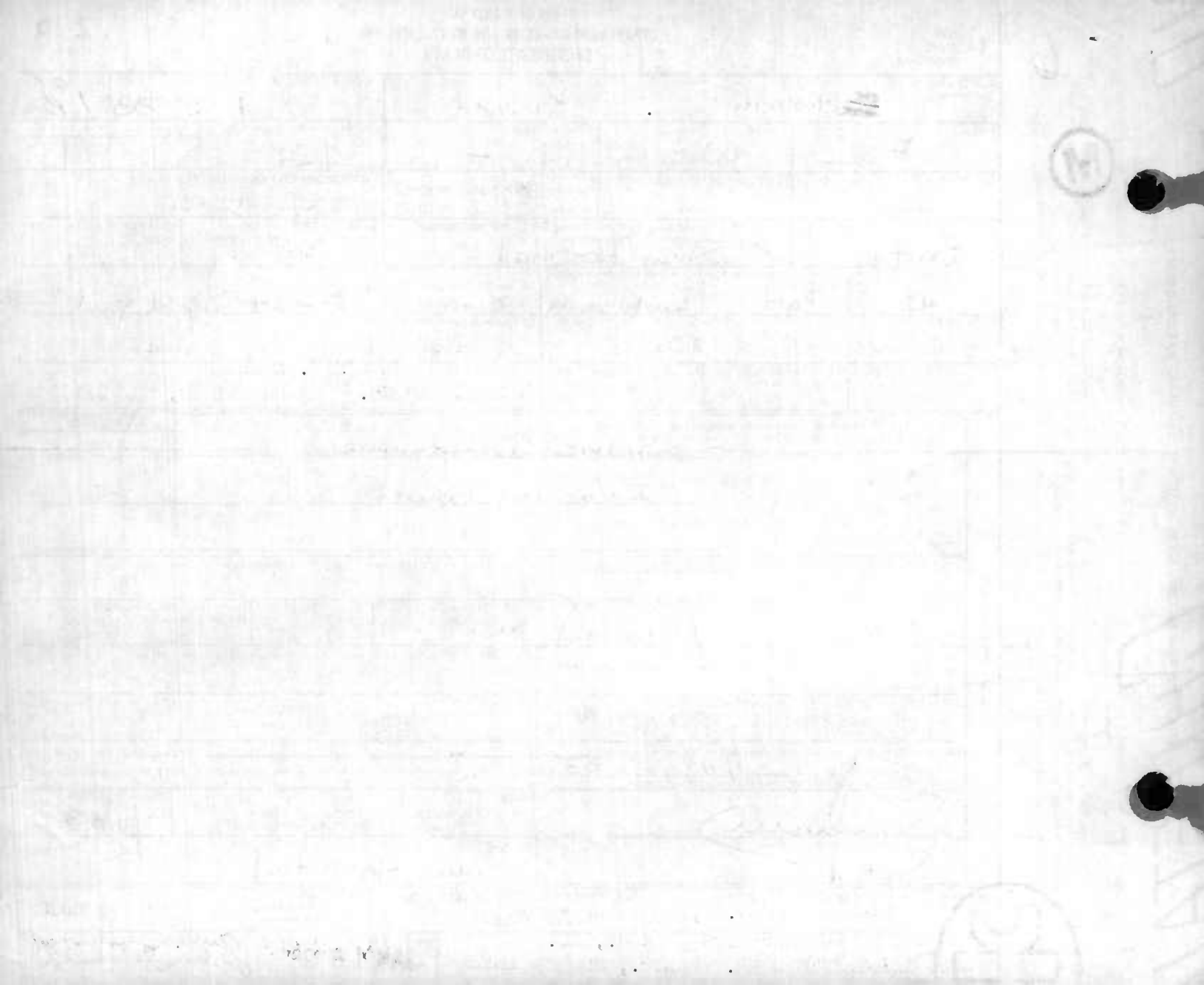
|   |                                   |   |   |
|---|-----------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  | 23b. DATE<br><b>JAN. 12, 1983</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HEBREW YOUNG MEN</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY<br><b>BALTIMORE MARYLAND</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b><br>ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b> |                                   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 18 1983</b>           |   |
|   |                                   | 25b. REGISTRAR'S SIGNATURE<br><b>J. J. Carver</b>             |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in person.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |   |  |   |   |  |  |
|--|--|--|--|---|---|--|---|---|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   | REG. NO. 8301127  |  |   |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Anthony J. Lapertina</b>   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>01/18/83</b>   |  |   | 2b. HOUR<br><b>4:00 AM</b>  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Cauc.</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>04 09 1904</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.  |   | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                            |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>City Hospital</b> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>              |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>1118 Steelton Ave. 21224</b>  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Antino Lapertina</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Anna ? ?</b>   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>162-03-1427</b>   |  | 17. INFORMANT ADDRESS<br><b>Mrs. Myrtle J. Lapertina</b>  |   |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Coronary Artery Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetic Mellitus</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d): |  |  |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>short duration</b><br><b>many years</b>                              |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |  |   |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/18</b> 19 <b>82</b> to <b>12/18</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (or) (I) (we) did not view the body after death.   |  |  |  |   |   |  |   |   |  |  |
| 22b. SIGNATURE OF PHYSICIAN<br><b>Paul G. Koukoulas</b>  |  |  |  |   | DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED<br><b>1/18/83</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PAUL G. KOUKOULAS, M.D., P.A.S</b>   |  |  |  |   | 22e. ADDRESS<br><b>1708 Dundalk Ave #21222</b>  |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>01/21/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn</b>   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>                                 |   |   |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Walter Dabrowski</b>   |  |  |  |   | ADDRESS<br><b>1005 Dundalk Ave, 21224</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 21 1983</b> |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i> |  |

BP



Baltimore City

USA

located

with Hospital

Baltimore

111 Steelton Ave. 1112

Baltimore

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101-01-1017

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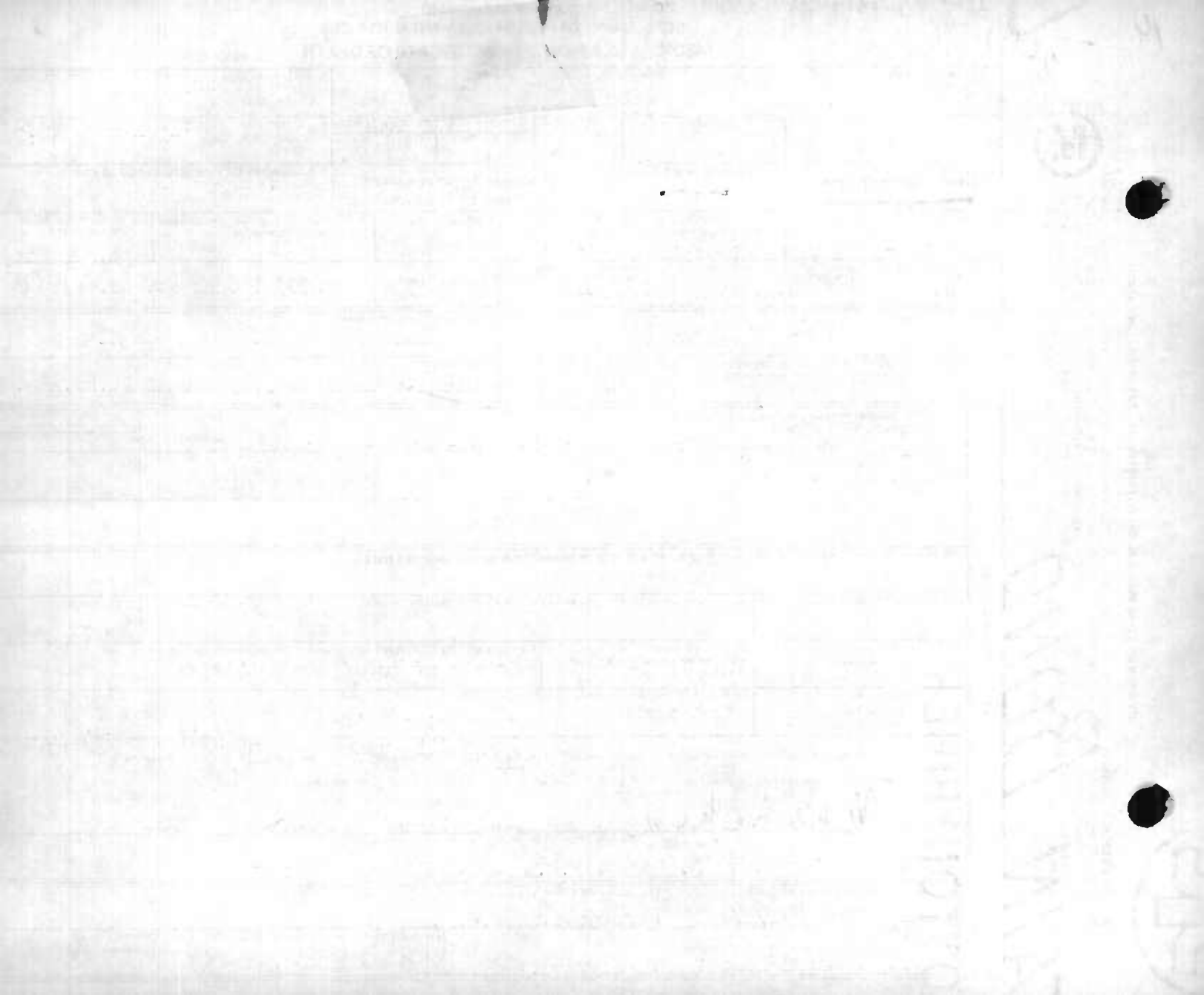
101-01-1017

101-01-1017

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |   |  |  |  |   |   |   |                      | REG. NO. 01128                               |  |
|--|--|---|--|--|--|---|---|---|----------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ANDRE Ernest LAPOINTE</b>   |  |   |  |  |  |   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>1-29-83</b> |   | 2b. HOUR <b>1:34</b> |  |  |
| 3. SEX <b>male</b>   |  | 4. RACE <b>white</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>June</b> DAY <b>3</b> YEAR <b>1925</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>57 YRS.</b>  |   | 7. IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN. <b>0</b>                          |                      | 2c. DATE PRONOUNCED DEAD <b>1-29-83</b>      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Hampshire</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>  |   |   |                      |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Engineer</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>Dept. of Navy</b>  |                      |  |  |
| 13a. STATE <b>Md.</b>  |  | 13b. COUNTY <b>A.A.Co.</b>  |  | 13c. CITY OR TOWN <b>Annapolis</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 13e. STREET ADDRESS <b>3709 Thomas Pt. Rd. 21403</b>  |                      |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Emile</b> MIDDLE <b>R.</b> LAST <b>LaPointe</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Blanche</b> MIDDLE <b>M.</b> LAST <b>Gagne</b>  |  |   |   |   |                      |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b>  |  | 16b. SOCIAL SECURITY NO. <b>42-46</b>   |  | 17. INFORMANT <b>Michael LaPointe</b>  |  | ADDRESS <b>3709 Thomas Pt. Rd. Ann. Md.</b>   |   |   |                      |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>8120 IMMEDIATE CAUSE (a) Trauma thoracic aorta with complications</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |  |  |  |   |   |   |                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |  |  |   |   |   |                      |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |   | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                      |                      |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |   |  | 21b. TIME OF INJURY <b>10:50AM TO 10:13-82</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>driver of auto/auto collision</b>  |   |   |                      |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>  |  | 21f. LOCATION<br>STREET <b>Forest Drive 50' from Forest Hill Avenue</b><br>CITY OR TOWN <b>Annapolis, Maryland</b><br>COUNTY <b>Prince Georges</b> STATE <b>Md.</b> |   |   |                      |  |  |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |  |  |   |   |   |                      |  |  |
| ACTUAL SIGNATURE <b>Margarita A. Korell</b>  |  |   |  | TITLE (SPECIFY) <b>M.D. Assistant</b>  |  |   |   | DATE <b>1-30-83</b>   |                      |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>   |  |   |  | ADDRESS <b>111 Penn Street</b>   |  |   |   |   |                      |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |   |  | 23b. DATE <b>2/3/83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Crownsville V.A. Cem.</b>   |   | 23d. LOCATION<br>CITY OR TOWN <b>Crownsville Md.</b><br>COUNTY <b>Prince Georges</b> STATE <b>Md.</b> |                      |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Hardesty Funeral Home</b><br>ADDRESS <b>12 Ridgely Ave. Ann. Md.</b>   |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 1 1983</b>   |   | 25b. REGISTRAR'S SIGNATURE <b>John J. Gough</b>   |                      |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 1 2 9

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |   |  |   |  |                                    |  |
|--|--|--|---|---|---|--|---|--|------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Maurice</i> <i>Lazoff</i>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>1 20 83</i>                        |   |   | 2b. HOUR<br><i>11:26 A.M.</i>  |   |  |                                    |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JULY 27, 1905</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>CANADA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |  |                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SELF-EMPLOYED</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>OIL DELIVERY</b>   |                                    |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |   | 13c. CITY OR TOWN<br><b>BALTO.</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 13e. STREET ADDRESS<br><b>APT. B-3<br/>25 WARREN PARK DR. #21208</b>   |                                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>SOLOMON LAZOFF</b>  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>DORA UNKNOWN</b>  |   |  |   |  |                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-10-8450</b>  |   | 17. INFORMANT <b>BERNARD LAZOFF</b><br><b>8025 MONTWOOD RD. BALTO., MD 21207</b>  |   |  |   |  |                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>5570 IMMEDIATE CAUSE (a) Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Renal Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Removal Necrotic Large Bowel</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 days</b> |  |  |   |   |   |  |   |  |                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Past Hx MI</b>   |  |  |   |   |   |  |   |  |                                    |  |
| 19a. DATE OF OPERATION<br><b>1/10/83</b>   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Necrotic Bowel</b> |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>              |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |                                    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(1st HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/8/83</b> 19 <b>83</b> to <b>1/20</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1/20/83</b> 19 <b>83</b> , and that (I) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.              |  |  |   |   |   |  |   |  |                                    |  |
| 22b. SIGNATURE<br><i>Murray Suskin</i>   |  |  | DEGREE  |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>1/20/83</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Murray Suskin</b>  |  |  | 22e. ADDRESS<br><b>Sinai Hospital</b>                                     |   |   |  |   |  |                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>   |  |  | 23b. DATE<br><b>JAN. 21, 1983</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BETH HAMEDROSH HAGODOL</b>                                     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROSEDALE BALTO. MD</b> |  |                                    |  |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b><br>NAME ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR <b>JAN 26 1983</b><br>25b. REGISTRAR'S SIGNATURE<br><i>John J. Connel</i> |  |   |  |                                    |  |

MEDICAL CERTIFICATION



CO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |   | 83 01130   |   |
|---|--|--|---|--|---|
| 1. STATE REGISTRAR  |  | CERTIFICATE OF DEATH   |   |  |   |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 2a. DATE OF DEATH  |   | 2b. HOUR   |   |
| JOHN D. LEBRUN  |  | JANUARY 28, 1983   |   | 10:25 M  |   |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | 7. IF UNDER 1 YEAR   |   |
| Male  | White  | March 9 1933   | 49 YRS.   | IF UNDER 24 HRS  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |   |
| Maryland  | USA  |  | BALTIMORE CITY MD.  |  |   |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY                           |
| BALTIMORE   | THE JOHNS HOPKINS HOSPITAL   |  | Sales Est.  |  | Machinery   |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS  |   |
| Md.   | A.A.   | Severna Park   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 561 West Dr. (21146)   |   |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |   |  |   |
| John LeBrun   |  | Doris Lein   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS  |   |
| No  |  | 215-30-6749  |   | Helen Whitmer (same as 13e)  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>1629 IMMEDIATE CAUSE (a) Metastatic adenocarcinoma of lung<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>6/82 - 1/83 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 6  |  |  |   |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?  |   |
|   |  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/28, 19 83, to 1/28, 19 83, that (I) (we) lost<br>saw the deceased alive on 1/28, 19 83, and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) did (did not) view the body after death.                                   |  | 22b. SIGNATURE<br>Eric L. Johnson  |   | 22c. DATE SIGNED<br>1/28/83  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |   | 22f. DEGREE<br>MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |
| Eric L. Johnson   |  | Johns Hopkins Hospital   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |   |
| Burial  |  | 1/31/83  |   | Glen Haven Memorial  |   |
| 24. FUNERAL DIRECTOR NAME   |  | 24b. ADDRESS   |   | 25a. DATE OF DEATH BY REGISTRATION   |   |
| George J. Gonce   |  | F.H. 4001 Ritchie Hwy.   |   | FEB 1 1983   |   |
| 25b. REGISTRAR'S SIGNATURE  |  | 25c. REGISTRAR'S SIGNATURE   |   |  |   |
| John J. Gonce   |  | John J. Gonce  |   |  |   |



1008 1008 1008

16) 1000 1000 1000 (1000 1000 1000)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8301131

1- FOR  
STATE  
REGISTRAR

REG. NO.

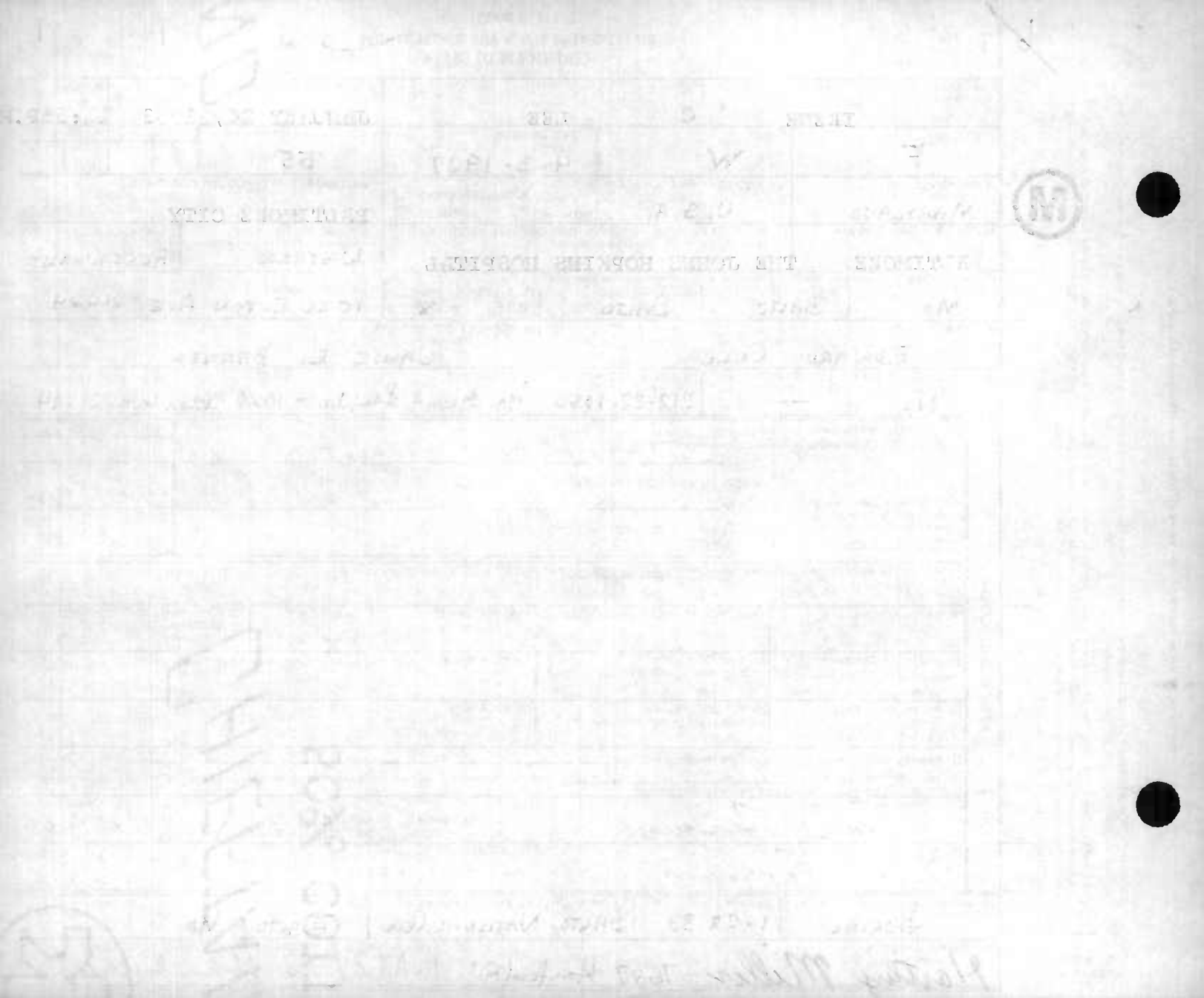
|   |  |   |   |   |   |
|---|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>TRENE C. LEE</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 24, 1983</b>                      |   | 2b. HOUR<br><b>11:55P.</b>  |
| 3. SEX<br><b>F</b>  | 4. RACE<br><b>W</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4-3-1927</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b> YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>WAITRESS</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RESTAURANT</b>              |
| 13a. STATE<br><b>MD.</b>  |  | 13b. COUNTY<br><b>BALTO.</b>  | 13c. CITY OR TOWN<br><b>BALTO.</b>  | 13d. INSIDE-CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>1020 ELTON AVE. 21224</b>                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>EDWARD COLE</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>JANIE E. BARNES</b>             |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-22-1050</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Mr. Glen A. Lee, Jr. - 1020 Elton Ave. 21224</b>                 |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>1809 IMMEDIATE CAUSE (a) Cardio-Respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Cervical Cancer.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Approx 1 yr.</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Probable Renal Failure</b>   |  |   |   |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/24</b> , 19 <b>82</b> , to <b>1/24</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/24</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death.                 |  |   |   |   |   |
| 22b. SIGNATURE<br><b>Dale Ferguson</b>  |  |   |   | 22c. DATE SIGNED<br><b>1/25/82</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dale Ferguson</b>   |  |   |   | 22e. ADDRESS<br><b>1654 Waverly Way Balto Md</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>1-28-83</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTO. NATIONAL CEM.</b>                               |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b>   |  |   |   |   |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Hartley Miller - 7507 Hanford Rd.</b>  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 27 1983</b>   |   |
|   |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>   |   |

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

83 01132

|   |   |   |  |   |  |
|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Pearl Lee</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 30, 1983</b>   |   | 2b. HOUR<br>P M<br><b>7:40 P M</b>   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Caucasian</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 25, 1893</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>89</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>                     |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>          |   |  |
| 13a. STATE<br><b>Maryland</b>   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13e. STREET ADDRESS<br><b>501 West Franklin Street 21201</b>   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thomas Evans</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Ann Evans</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>  | 17. INFORMANT<br><b>Pearl M. Wagner</b> ADDRESS<br><b>2004 Tinker Drive<br/>Ft. Washington, MD 20744</b> |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>4960</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Congestive Heart Failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Chronic Obstructive Pulmonary Disease</b> |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>years</b><br><b>years</b>                             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>R hip fracture ACCIDENT</b>   |   |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>1/10/83</b>  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Right Hip Fracture</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>2:45 P.M. 1 2 83</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>Subject fell</b> |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input checked="" type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>nursing home</b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>501 W. Franklin St. Balto. Md.</b>            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>January 2, 19 83</b> to <b>January 30, 19 83</b> , that (X) (we) lost saw the deceased alive on <b>January 30, 19 83</b> , and that in (my) (our) opinion death occurred on the date stated and from the causes stated above. (X) (we) (did) (do not) view the body after death.  |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Michael Rossini Jr. M.D.</b>   |   | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>1/30/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Michael Rossini Jr., M.D.</b>   |   | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |   | 23b. DATE<br><b>February 1, 1983</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lee's Crematory</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Washington, DC</b>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Lee Funeral Home, Inc.</b>   |   | 25a. DATE REC'D. BY REGISTRAR (X) REGISTRAR'S SIGNATURE<br><b>FEB 4 1983</b>  |  | 25b. DATE REC'D. BY REGISTRAR (X) REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                      |  |

20% CO<sub>2</sub> (M-21)

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |         |                  |  |                |                  |  |  |  |   |  |  |  |  |  |
|---|---------|------------------|--|----------------|------------------|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         |                  | FIRST MIDDLE LAST  |                |                  | 2a. DATE KNOWN OF DEATH  |  |  | MONTH DAY YEAR  |  |  | 2b. HOUR                                     |  |  |
| Brian Charles Lewandowski   |         |                  |  |                |                  | 14 19 83   |  |  | 14 19 83  |  |  | 11:13 a.m.                                   |  |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS)  | IF UNDER 1 YR. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD   |  |  | MONTH DAY YEAR  |  |  | 2d. HOUR                                     |  |  |
| Male  | White   | 11 14 82         | 2  | 2              | 2                | 14 19 83   |  |  | 14 19 83  |  |  | 11:13 a.m.                                   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         |                  | 7b. CITIZEN OF WHAT COUNTRY?   |                |                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |  |  |
| Maryland  |         |                  | U.S.A.   |                |                  |  |  |  | Baltimore City, MD.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |         |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |
| Baltimore   |         |                  | Baltimore City Hospital  |                |                  | Dependent  |  |  |   |  |  |  |  |  |
| 13a. STATE  |         |                  | 13b. COUNTY  |                |                  | 13c. CITY OR TOWN  |  |  | 13d. INSIDE CITY LIMITS?  |  |  | 13e. STREET ADDRESS                          |  |  |
| Maryland  |         |                  | Baltimore  |                |                  | Dundalk  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 |  |  | 1609 Four Georges Ct. Apt. A-2 21222         |  |  |
| 14. FATHER'S NAME   |         |                  | 15. MOTHER'S MAIDEN NAME   |                |                  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT                                |  |  |
| Bryan J. Lewandowski  |         |                  | Mary Elizabeth Lam   |                |                  | No   |  |  | None  |  |  | Bryan J. Lewandowski-Balto. MD. 21222        |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>7980 IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |         |                  |  |                |                  |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |         |                  |  |                |                  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |         |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                |                  |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                |                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |         |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |                |                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . |         |                  |  |                |                  |  |  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE  |         |                  | TITLE (SPECIFY)  |                |                  |  |  |  | DATE SIGNED   |  |  |  |  |  |
| Thomas D. Smith, M.D.   |         |                  | M.D. Deputy Chief  |                |                  |  |  |  | 1/15/83   |  |  |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |         |                  | ADDRESS  |                |                  |  |  |  |   |  |  |  |  |  |
| Thomas D. Smith, M.D.   |         |                  | 111 Penn St. Balto., MD.   |                |                  |  |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |         |                  | 23b. DATE  |                |                  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| Burial  |         |                  | 1/18/83  |                |                  | Meadowridge  |  |  | Dorsey Howard Maryland  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME  |         |                  | 24a. ADDRESS   |                |                  | 25a. DATE REC'D. BY REGISTRAR  |  |  | REGISTRAR'S SIGNATURE   |  |  |  |  |  |
| Duda-Ruck, Inc.   |         |                  | 7922 Wise Avenue Dundalk, MD. 21222  |                |                  | JAN 18 1983  |  |  | John J. Carver  |  |  |  |  |  |

RECEIVED  
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JAN 10 1964





FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 1 3 4

REG. NO.

|  |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JATRUS BELT LEWIS</b><br><i>Jainus Belt Lewis</i>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 18 83</b>   |  |   |  | 2b. HOUR<br><b>2<sup>19</sup> PM</b>   |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>Cauc</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 29 22</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balt. City</b> MD.                             |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balt.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South. Balt. Gen. Hosp.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Engineer</b>       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Beth. Steel</b>  |  |
| 13a. STATE<br><b>MD</b>  |  |   |  | 13b. COUNTY<br><b>--</b>  |  | 13c. CITY OR TOWN<br><b>Balt.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James W. Lewis</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Oella Belt</b>  |  |   |  | 13e. STREET ADDRESS<br><b>615 N. Decker Ave.</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes WWII</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>215-14-0076</b>  |  | 17. INFORMANT<br><b>Baltimore, Md. 21205</b><br><b>Florence Lewis, 615 N. Decker Ave,</b> |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>4149</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cardiac arrhythmia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>Severe atherosclerotic coronary artery disease</b> |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/21/83</b> , 19 <b>83</b> , to <b>1/18</b> , 19 <b>83</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/18</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                           |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Karen Newton</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><b>1/18/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KAREN NEWTON</b>   |  |   |  | 22e. ADDRESS<br><b>S. BALTO. GEN'L HOSPITAL</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/22/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Schimunek Funeral Home</b><br><b>3331 Brehms Lane, Balto, Md.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 21 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Ganiel</b>                                       |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 above any injury, or other traumatic event, the medical examiner will be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 83 01135   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>WALTER E. LEWIS   |  |   |  | 2b. HOUR 1 4 M  |  |  |  |
| 3. SEX Male   |  | 4. RACE White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>3-8-1902   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS   |  |
| 7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY)<br>Ind.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balt. City. MD.                                      |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Lutheran Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Inspector  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Cabaret Distillery                                      |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>Ind.  |  | 13b. COUNTY<br>—  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Walter Jr. Lewis   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Lilly White   |  | 13e. STREET ADDRESS<br>1820 Spence St.  |  | 212 30.  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>NW 212-14-8491  |  | 17. INFORMANT NAME ADDRESS<br>Chelda Lewis 3417 Hopkins Blvd  |  | 212 30   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST<br>1739<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) CARCINOMA E METASTASES<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from 12/21, 19 82, to 1/4, 19 83, that (we) lost the deceased alive on 1/4, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>R. Foreman  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>1/4/83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RAYMOND A. FOREMAN   |  |   |  | 22e. ADDRESS<br>Lutheran Hospital   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>burial   |  | 23b. DATE<br>1-7-1983   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Landon Park Cem.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Balt. Ind.  |  |
| 24. FUNERAL DIRECTOR NAME<br>JOHN J. COWAN & SON INC. 901 HOLLINS ST.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 11 1983  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Cowan  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 1 3 6

REG. NO.

|   |  |  |   |   |  |
|---|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>IRA LIBERMAN</b>  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1 9 83</b>  |   | 2b. HOUR<br><b>1:35 PM</b>  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>MAR. 22, 1909</b>   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS  |   | IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>M ARLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD</b>  |  |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ACCOUNTANT</b>   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>ACCOUNTING</b>  |  |  |   |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   |   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>BALTIMORE,</b>  |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>APT. 805<br/>6210 PARK HTS. AVE. #21215</b>  |   |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>ABRAHAM LIBERMAN</b>  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>BLANCHE LIBERMAN</b> |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>217-01-2163</b>  |   | 17. INFORMANT<br><b>DR. SIDNEY LIBERMAN APT. 805<br/>6210 PARK HTS. AVE. BALTO., MD 21215</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sepsis</b><br>4850<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Due to, or as a consequence of</b>       |  |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Dehydration, renal failure</b>   |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 8</b> , 19 <b>83</b> , to <b>Jan 9</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>Jan 9</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |
| 22b. SIGNATURE<br><b>Dr. Hernandez</b>  |  | DEGREE<br><b>MD</b>  |   | 22c. DATE SIGNED<br><b>1-9-83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. HERNANDEZ</b>   |  | 22e. ADDRESS<br><b>ST. AGNES HOSP. - BALTO. MD</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>JAN. 10, 1983</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HEBREW FRIENDSHIP</b>  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY<br><b>BALTIMORE MARYLAND</b>   |  |  |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>   |  | ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 12 1983</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>   |  |  |   |   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8301137

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ANNIE ELIZABETH DUMAS LITTLE</b> |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JANUARY 6 1983</b>              |   | 2b. HOUR<br><b>11:52AM</b>                       |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>NEGRO</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>AUG 31 18</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Anderson, N.C.</b>      | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE CITY</b>                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN HIGH FACILITY, GIVE STREET ADDRESS)<br><b>CHURCH HOME HOSPITAL</b> |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>NONE</b> |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>DAVE DUMAS</b>             |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>JENNIE BENNETT</b> |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)    |  | 16b. SOCIAL SECURITY NO.<br><b>245-16-0143</b>  |  | 17. INFORMANT ADDRESS<br><b>Mr. Bonnie Dumas 940 Bennett Pl 21223</b>                           |  |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY: **QUESTIONABLE METASTATIC CARCINOMA**

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

**1749**  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) **CARCINOMA OF THE BREAST**  
(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**CIRRHOSIS OF THE LIVER; CHRONIC ALCOHOLISM**

|  |  |  |   |
|--|--|--|---|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)        |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>1/4</b> , 19 <b>83</b> , to <b>1/6</b> , 19 <b>83</b> , that (1) we last saw the deceased alive on <b>1/6</b> , 19 <b>83</b> , and that in (my) <b>our</b> opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death. |  |  |   |

|   |                     |  |                                   |
|---|---------------------|--|-----------------------------------|
| 22a. SIGNATURE<br><b>Paul E. Gormley, M.D.</b>                        | DEGREE<br><b>MD</b> | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br><b>1/6/83</b> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PAUL E. GORMLEY, M.D.</b> |                     | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION<br/>100 NORTH BROADWAY BALTIMORE, MD 2123</b>   |                                   |

|  |                             |   |   |
|--|-----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)<br><b>Burial</b> | 23b. DATE<br><b>1/10/83</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bessie Chapel Cemetery</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Livesville, North Carolina</b> |
|--|-----------------------------|---|---|

|  |   |  |
|--|---|--|
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March Funeral Home, Inc. / 1101 E. North Ave</b> | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 10 1983</b> | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b> |
|--|---|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



24515

10/10/01

Jan 10 1901  
U.S. DEPT. OF AGRICULTURE  
WASHINGTON, D.C.

Item #5&amp;6 Film G575 1/26/83 rc

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 1 3 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |                            |  |  |
|--|--|--|---|---|----------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>WILLIAM LITTLEJOHN</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 4, 1983</b> |   | 2b. HOUR<br><b>12:20AM</b> |  |  |
| 3 SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 10, 1931</b>  |                            | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>51</b> YRS.<br>IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>South Car.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |                            | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b> |  | 13b. COUNTY<br><b>Balto.</b>   |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                            | 13d. STREET ADDRESS<br><b>1910 Wilmont Ct.</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |   |   |                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>yes</b>           |  | 16b. SOCIAL SECURITY NO.<br><b>212 287 895</b>   |   | 17. INFORMANT ADDRESS<br><b>Mary Clark 2204 Allendale Rd.</b>   |                            |  |  |

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br><b>3030</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Liver Disease, Sepsis, Bleeding</b><br>(c) <b>GCH Abuse</b> |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Immediate</b> |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/4/83</b> to <b>1/4/83</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/4/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death                       |  |  |  |  |  |
| 22b. SIGNATURE<br><b>G. D. K. P. M. H.</b>   |  | DEGREE   |  | 22c. DATE SIGNED<br><b>1/4/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>K. P. M. H.</b>  |  | 22e. ADDRESS<br><b>JOHN HOPKINS Hospital</b>                           |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/8/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Zion Cem.</b>                           |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 7 1983</b>                     |  |  |  |

|  |  |   |  |
|--|--|---|--|
| 24. FUNERAL DIRECTOR<br>(NAME)<br><b>LEROY O. DYETT 4600 LIBERTY HGTS AVE.</b> |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b> |  |
|--|--|---|--|



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 1 3 9

REG. NO.

|   |  |  |  |  |                                    |  |                    |  |
|---|--|--|--|--|------------------------------------|--|--------------------|--|
| 1. FOR STATE REGISTRAR  |  |  | 2a. DATE OF DEATH  |  |                                    | 2b. HOUR   |                    |  |
| I. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | 3. SEX   |  |                                    | 4. RACE  |                    |  |
| JOHN T. LIVESAY   |  |  | Male   |  |                                    | White  |                    |  |
| 5. DATE OF BIRTH  |  |  | 6. AGE   |  |                                    | 7. BALTIMORE CITY OR COUNTY OF DEATH   |                    |  |
| MONTH 8 DAY 28 YEAR 21  |  |  | 61 YRS.  |  |                                    | Baltimore City MD.   |                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |                                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                    |  |
| Maryland  |  |  | U.S.A.   |  |                                    |  |                    |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |                    |  |
| Baltimore   |  |  | St. Agnes Hospital   |  |                                    | City Police  |                    |  |
| 13a. STATE  |  |  | 13b. COUNTY  |  |                                    | 13c. STREET ADDRESS  |                    |  |
| Maryland  |  |  | Violetville  |  |                                    | 3808 Benson Avenue 21227   |                    |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |  |                                    | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |                    |  |
| John T. Livesay   |  |  | Ethel Behrens  |  |                                    | YES WW II  |                    |  |
| 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT  |  |                                    | ADDRESS  |                    |  |
| 220-25-7043   |  |  | Ethel V. Livesay   |  |                                    | 3808 Benson Ave. 21227   |                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |  |  |  |                                    |  |                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |                                    |  |                    |  |
| IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u>  |  |  |  |  |                                    |  |                    |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>TERMINAL LUNG CARCINOMA</u>   |  |  |  |  |                                    |  |                    |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____  |  |  |  |  |                                    |  |                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____  |  |  |  |  |                                    |  |                    |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |                                    | 20a. AUTOPSY?  |                    | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|   |  |  |  |  |                                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                    | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY  |  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                    |  |
|   |  |  | HOUR A.M. MONTH DAY YEAR   |  |                                    |  |                    |  |
|   |  |  | P.M. 19  |  |                                    |  |                    |  |
| 21d. INJURY OCCURRED  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |                                    | 21f. LOCATION  |                    |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  |  |  |                                    | CITY OR TOWN COUNTY STATE  |                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |                                    |  |                    |  |
| 22b. SIGNATURE  |  |  | DEGREE   |  |                                    | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |                    | 22c. DATE SIGNED   |
| Leonard E Bienkowski  |  |  | M.D.   |  |                                    |  |                    | 1/3/83   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  | 22e. ADDRESS   |  |                                    |  |                    |  |
| LEONARD BIENKOWSKI M.D.   |  |  | ST. AGNES HOSPITAL BALT., MD   |  |                                    |  |                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION      |  |
| Burial  |  |  | 1/6/83   |  | New Cathedral Cem.                 |  | Baltimore Maryland |  |
| 24. FUNERAL DIRECTOR  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |                                    | 25b. REGISTRAR'S SIGNATURE   |                    |  |
| NAME ADDRESS 21229  |  |  | JAN 5 1983   |  |                                    | John J. Conner   |                    |  |
| Hubbard Funeral Home, Inc. 4107 Wilkens Ave.  |  |  |  |  |                                    |  |                    |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that this certificate be detached within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 1 4 0

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ELLIS RUSSELL LOCKARD</b> |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01/27/83</b> |   |  | 2b. HOUR<br><b>8:00pm</b>   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>AUG. 26 1913</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Coal Miner</b> |  |
| 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |   |  |   |  |

|   |  |  |  |   |  |   |  |   |  |
|---|--|--|--|---|--|---|--|---|--|
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b> |  | 13b. COUNTY<br><b>---</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                     |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3958 Southclaire Road 21213</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Martin Luther Lockard</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary --- Lee</b>      |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWII</b> |  | 17. INFORMANT<br>ADDRESS<br><b>George Lockard 709 S. Grundy St. 21224</b> |  |   |  |   |  |

|  |  |   |  |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio Pulmonary Arrest</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Myocardial Infarction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>ASCVD</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>30 sec</b><br><b>1 day</b> |  |
|--|--|---|--|

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Lower extremity ischemia 2° poor perfusion</b>  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>1/26/83</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>UNSTABLE ANGINA</b> |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)     |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/26/83</b> , 19 <b>83</b> , to <b>1/27</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1/27</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |

|  |  |   |  |                                    |  |
|--|--|---|--|------------------------------------|--|
| 22b. SIGNATURE<br><b>E Ruas MD</b>                   |  | DEGREE  |  | 22c. DATE SIGNED<br><b>1/27/83</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RUAS</b> |  | 22e. ADDRESS<br><b>JOHNS HOPKINS Hospital</b> |  |                                    |  |

|  |  |                                 |  |   |  |   |  |
|--|--|---------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>Jan.31 1983</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mays Chapel Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |  |
|--|--|---------------------------------|--|---|--|---|--|

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|---|--|--|--|---|--|
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Lilly &amp; Zeiler, Inc. 700 S. Conkling St.</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 1 1983</b> |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Givish</b> |  |
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 3 0 1 1 4 1   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Minnie Lockner</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>January 29 1983</b>  |  | 2b. HOUR<br><b>6:00 AM</b>   |  |
| 3. SEX<br><b>female</b>   |  | 4. RACE<br><b>white</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Oct. 4, 1910</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore, Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>household</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>housewife</b>  |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>A.A. Co.</b>   |  | 13c. CITY OR TOWN<br><b>Odenton</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Max Green</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary Sindler</b>  |  | 13e. STREET ADDRESS<br><b>1151 Odenton Rd. 21113</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215-22-3679</b>   |  | 17. INFORMANT ADDRESS<br><b>Calvin Earl Lockner same as 13e.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>2506 IMMEDIATE CAUSE (a) Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Gangrene Left Foot</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes Mellitus</b>   |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Two Weeks</b><br><b>Four Weeks</b><br><b>40 Years</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>11/12/82</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Peripheral Vascular Disease</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 3, 1982</b> , to <b>January 29, 1983</b> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <b>January 29, 1983</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>E. J. McDonnell Jr.</b>  |  | DEGREE<br><b>ATTENDING PHYSICIAN</b>   |  | MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  | 22c. DATE SIGNED<br><b>1/29/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>E. J. McDonnell Jr., M.D.</b>   |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>2/1/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Crematory</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Hardesty Funeral Home</b>   |  | ADDRESS<br><b>12 Ridgely Ave. Ann. Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 1 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>  |  |



Minute

Location

January 20 1983

Baltimore City

Marland General Hospital

Unidentified

Report

Cardiomyopathy

Diabetes Mellitus

Pericardial Vascular Disease

11/12/82

X

January 20

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November 2

82

January 20

83

KX KX

Marland General Hospital



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 1 4 2

REG. NO.

|   |   |   |   |  |                             |
|---|---|---|---|--|-----------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><i>James F Lofton</i>  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>1 8 83</i> |  | 2b. HOUR<br><i>11:34 AM</i> |
| 3. SEX<br><i>Male</i>   | 4. RACE<br><i>Black</i>                       | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>07 21 23</i>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>59</i> YRS.  |                             |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>N.C.</i>  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Balto. City</i> MD.   |                             |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Univ. of Md</i>                             |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |                             |
| 13a. STATE<br><i>Md</i>   |   | 13b. COUNTY   | 13c. CITY OR TOWN<br><i>Balt</i>                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                             |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>William Lofton</i>  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Mary Blaney</i>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <i>NO</i>   |                             |
| 16b. SOCIAL SECURITY NO.<br><i>22589600</i>   |   | 17. INFORMANT ADDRESS<br><i>Doris Manning 921 Allendale St.</i>   |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><i>0389</i> IMMEDIATE CAUSE (a) <i>Sepsis - Cardiovascular Collapse</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Unknown</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i></i> |                             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i></i>  |   |   |   |  |                             |
| 19a. DATE OF OPERATION<br><i>None</i>   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                             |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)       |   |  |                             |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |                             |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |                             |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/7</i> , 19 <i>83</i> , to <i>1/8</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>1/8</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |   |  |                             |
| 22b. SIGNATURE<br><i>Kenneth Back</i>   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br><i>1/8/83</i>  |                             |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Kenneth Back</i>  |   | 22e. ADDRESS<br><i>Univ of Md Hosp</i>  |   |  |                             |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  | 23b. DATE<br><i>1/12/83</i>                   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Cedar Hill Cem.</i>  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Anne Arundel Co. MD</i>  |                             |
| 24. FUNERAL DIRECTOR NAME<br><i>Wm. C. March C/H</i>  |   | ADDRESS<br><i>1101 E. North Ave</i>   |   | 25a. DATE RECD BY REGISTRAR<br><i>JAN 10 1983</i>  |                             |
|   |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Carver</i>  |                             |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove co-bonoppers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. IF THE DEATH IS SUSPECTED TO BE A BURIAL - TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |                  |  |  |  |   |   |  |
|--|------------------|--|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>James Theodore McKinley Logan   |                  |  | 2a. DATE KNOWN OF DEATH<br>XX MONTH DAY YEAR<br>1 15 19 83       |  |   | 2b. HOUR<br>M<br>8:29A  |  |
| 3. SEX<br>male   | 4. RACE<br>Black | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 7 82  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br>2 2       | IF UNDER 24 HRS.<br>HOURS MIN.<br>15 19 83   |   | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>1 15 19 83                            |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto., Md.  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                         |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinai Hospital |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| 13a. STATE<br>Md.  |                  | 13b. COUNTY<br>BALTIMORE   | 13c. CITY OR TOWN<br>Balto.                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS<br>1801 Snow Meadow La. 21209                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Henry Logan  |                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Theodora Malden |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>no  |                  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS<br>James H. Logan 1801 Snow Meadow La.   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>7980 IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause lost.   |                  |  |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                  |  |  |  |   |   |  |
| 19a. DATE OF OPERATION   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21i. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: <u>Not a cause</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                  |  |  |  |   |   |  |
| ACTUAL SIGNATURE<br><i>Thomas D. Smith</i>   |                  | TITLE (SPECIFY)<br>M.D. Deputy Chief   |  |  |   | DATE SIGNED<br>1/16/83  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Thomas D. Smith, MD.   |                  | ADDRESS<br>111 Penn St. Balto., MD.  |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |                  | 23b. DATE<br>1/18/83   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Pk.   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., Md.                           |  |
| 24. FUNERAL DIRECTOR<br>LEROY O. DYETT 4600 LIBERTY HGTS. AVE.   |                  |  |  | 25a. DATE REC'D BY REGISTRAR<br>JAN 18 1983  |   | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Givens</i>                                 |  |



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Handwritten signature and date: 1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the event.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8-3 01144   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Esther H. Longley</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 13 83</b>   |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 14, 1891</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>91</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wash. D. C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Keswick Nursing Home</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Teacher</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Education</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. COUNTY <b>Dist. of Columbia</b>   |  |  |  | 13b. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 13c. CITY OR TOWN<br><b>Washington</b>  |  |  |  | 13d. STREET ADDRESS<br><b>3901 Connecticut Ave., N.W.</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Richard W. Henderson</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Esther J. Ferguson</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217 34 2732</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Read McCaffrey, Balto., MD 21201</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4292</b> IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardiovascular Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>5 yrs</b> |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 wks</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>13 JAN 1983</b> to <b>13 JAN 1983</b> , that (I) (we) last saw the deceased alive on <b>13 JAN 1983</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Aubrey D. Richardson</b>   |  |  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>13 JAN 1983</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Aubrey D. Richardson</b>  |  |  |  | 22e. ADDRESS<br><b>Keswick Home, Balto., MD</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/17/83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Langeland Mem. Cpl. Kalamazoo</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Michigan</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Henry W. Jenkins &amp; Sons Co.<br/>4905 York Road Balto., MD 21212</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 13 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>  |  |





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1. *in*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  | 8301145  |  |
|---|--|---|--|---|--|---|--|--|--|----------|--|
| FOR<br>1- STATE REGISTRAR   |  |   |  |   |  |   |  |  |  | REG. NO. |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Norma A. Lovell</i>  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>Jan 25 83</i>   |  | 2b. HOUR<br><i>3:18 PM</i>   |  |          |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>8 5 1922</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>60</i> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><i>3 18</i>   |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Ohio</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD                                |  |  |  |          |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Baltimore City Hospital</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i>            |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Maryland</i>   |  |   |  |   |  | 13b. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13c. STREET ADDRESS<br><i>1954 Dineen Drive 21222</i>  |  |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Luther V. Ayers</i>  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Clara A. Serger</i>                         |  |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>286-18-2595</i>   |  | 17. INFORMANT<br><i>Fred A. Lovell</i>  |  | ADDRESS<br><i>1954 Dineen Dr. Balto., MD. 21222</i>   |  |  |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br><i>4019</i> IMMEDIATE CAUSE (a) <i>Cardiac arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>hypertension</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Respiratory arrest</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |   |  |  |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)  |  |   |  |   |  |   |  |  |  |          |  |
| 19a. DATE OF OPERATION<br><i>2/9/83</i>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)   |  |   |  |  |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/24/83</i> , 19____, to <i>1/25/83</i> , 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.      |  |   |  |   |  |   |  |  |  |          |  |
| 22b. SIGNATURE<br><i>Bruce Kinosian</i> MD<br>DEGREE  |  |   |  |   |  | 22c. DATE SIGNED<br><i>1/25/83</i>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Bruce Kinosian</i>  |  |   |  |   |  | 22e. ADDRESS  |  |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>1/27/1983</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Sacred Ht. Of Jesus</i>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Dundalk Baltimore MD.</i>                      |  |  |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Duda-Ruck, Inc.</i><br>ADDRESS<br><i>7922 Wise Avenue Dundalk, MD. 21222</i>   |  |   |  |   |  | 25a. DATE REC'D BY REGISTRAR<br><i>JAN 27 1983</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Canine</i>  |  |          |  |

BP

1940-1

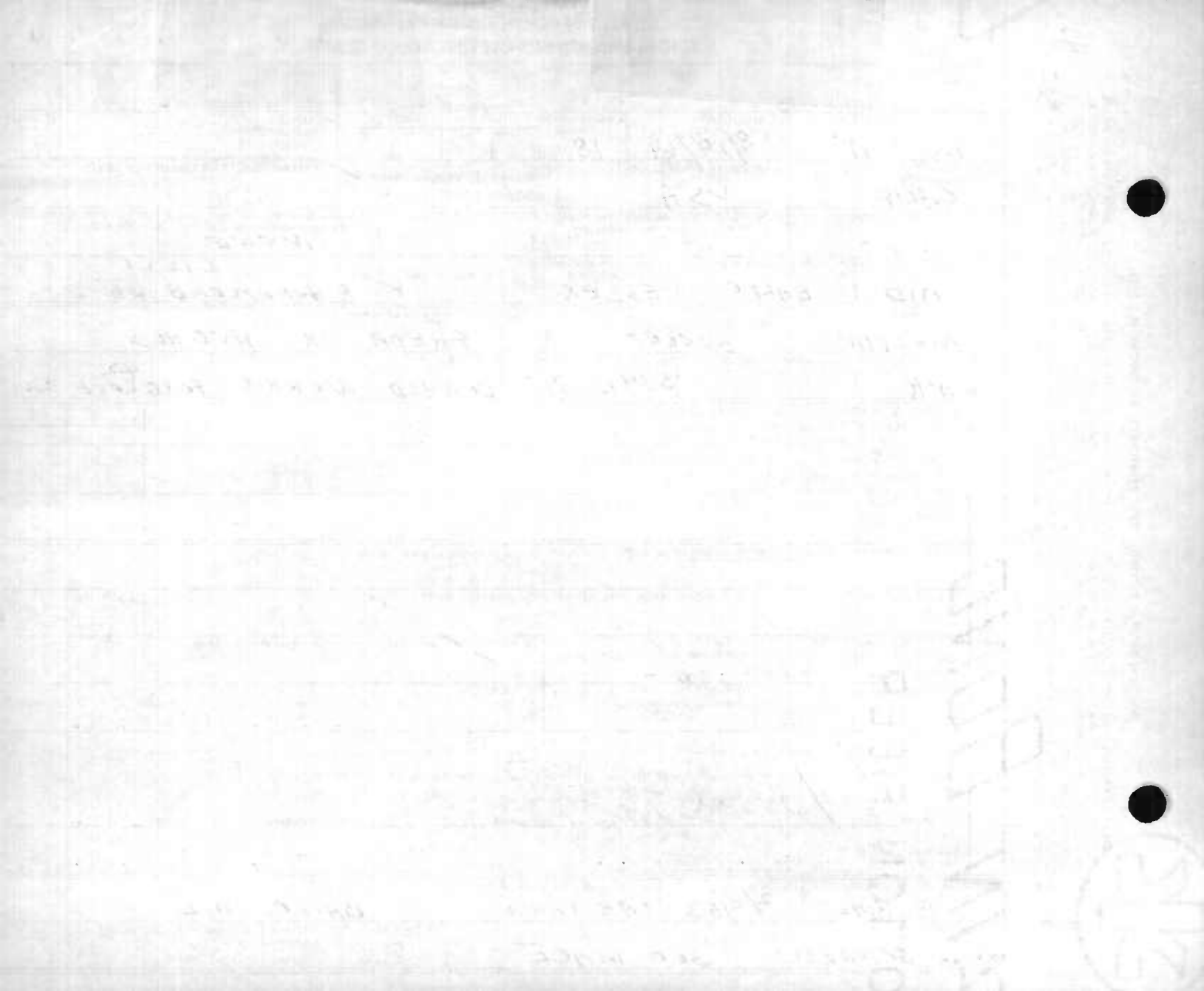


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |           |  |   |  |  |  |   |  | REG. NO. 83 01146                            |  |
|--|--|-----------|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |           |  |   |  |  |  |   |  | 7a. DATE KNOWN OF DEATH                      |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert Luckey   |  |           |  |   |  |  |  |   |  | 7b. HOUR 7:00                                |  |
| 2. SEX M   |  | 4. RACE W |  | 5. DATE OF BIRTH MONTH DAY YEAR 8/19/64   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 18 YRS.    |  | 7c. DATE PRONOUNCED DEAD 1-30 19 83   |  | 7d. HOUR 7:00                                |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CALIF.  |  |           |  | 9. CITIZEN OF WHAT COUNTRY? USA   |  |  |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |
| 11. CITY OR TOWN OF DEATH Baltimore  |  |           |  | 12. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital |  |  |  | 13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE   |  |  |  |
| 14. STATE MD   |  |           |  | 15. COUNTY BALTO  |  | 16. CITY OR TOWN ESSEX                     |  | 17. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 18. FATHER'S NAME FIRST MIDDLE LAST MELVIN LUCKEY  |  |           |  | 19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FREDA K. HUGHES  |  |  |  | 20. STREET ADDRESS 21221 8 HONEYCOMB RD.  |  |  |  |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) UNK  |  |           |  | 22. SOCIAL SECURITY NO. 559155715   |  | 23. INFORMANT DONALD MORRIS                |  |   |  | 24. ADDRESS 42 FOXGLOVE LN.                  |  |
| 25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Gunshot wound in the head<br>9554<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b)<br>(c)   |  |           |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |           |  |   |  |  |  |   |  |  |  |
| 26. DATE OF OPERATION  |  |           |  | 27. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  | 28. AUTOPSY? head only YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 29. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |           |  | 30. TIME OF INJURY HOUR AM. MONTH DAY YEAR 12:34 1-30 19 83   |  |  |  | 31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self inflicted   |  |  |  |
| 32. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |           |  | 33. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home   |  |  |  | 34. LOCATION STREET CITY OR TOWN COUNTY STATE 8 Honeycomb Road, Essex, Baltimore, Md.   |  |  |  |
| 35. I certify that I took charge of the remains described above, held on death resulted from: Not a cause <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |           |  |   |  |  |  |   |  |  |  |
| 36. ACTUAL SIGNATURE Thomas D. Smith, M.D.   |  |           |  | 37. TITLE (SPECIFY) Deputy Chief  |  |  |  | 38. DATE SIGNED 1-31-83   |  |  |  |
| 39. EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.  |  |           |  | 40. ADDRESS 111 Penn Street, Baltimore, Md.   |  |  |  |   |  |  |  |
| 41. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL  |  |           |  | 42. DATE 2/2/83   |  | 43. NAME OF CEMETERY OR CREMATORY OAK LAWN |  | 44. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD  |  |  |  |
| 45. FUNERAL DIRECTOR NAME J. G. CONNELLY   |  |           |  | 46. ADDRESS 300 MACE  |  |  |  | 47. DATE REC'D. BY REGISTRAR FEB 3 1983   |  | 48. REGISTRAR'S SIGNATURE John J. Connelly   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 01147

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ETHEL E. LUNDBERG</b> |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JANUARY 19, 1983</b>                         |   | 2b. HOUR<br><b>11:20 AM</b>                                      |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 1 1931</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>51</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                      | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Waitress</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Woolworth</b>            |
| 13a. STATE<br><b>Maryland</b>   |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Rosedale</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Walter F. Leard</b>                  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Victoria Grimms</b>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |   | 16b. SOCIAL SECURITY NO.<br><b>216-28-3435</b>  |   | 17. INFORMANT<br><b>113-A. Aspenwood Way</b><br><b>Balto., MD. 21237</b>                        |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

1919

IMMEDIATE CAUSE (a) **CARDIORESPIRATORY ARREST**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last(b) **GLIOBLASTOMA MULTIFORME**

DUE TO, OR AS A CONSEQUENCE OF

(c) **SEIZURES SECONDARY TO GLIOBLASTOMA MULTIFORME**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

MEDICAL CERTIFICATION

|  |  |  |  |  |   |
|--|--|--|--|--|---|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                               |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JANUARY 12, 19 83</b> to <b>JANUARY 19, 19 83</b> , that (I) (we) lost<br>saw the deceased alive on <b>JANUARY 19, 19 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |
| 22b. SIGNATURE<br><i>T. Kawaja</i>   |  | DEGREE   |  | 22c. DATE SIGNED<br><b>1/19/83</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>T. KAWAJA, M.D.</b>  |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL</b><br><b>100 NORTH BROADWAY, BALTIMORE, MD 21231</b> |  |  |   |

|  |                               |   |   |
|--|-------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>1/21/1983</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holly Hill</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>White Marsh Maryland</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Duda-Ruck, Inc.</b><br><b>7922 Wise Avenue Dundalk, MD. 21222</b> |                               | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 21 1983</b>     | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Connel</i>                       |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



CHIEF





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 01148

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HARRY Leon MACK Jr.</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-8-83</b>  |  | 2b. HOUR<br><b>2:20 PM</b>   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 19 22</b>  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>60</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lafayette Square Nsg. Center</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harry Mack Nellie</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Jedgwick</b>   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes</b>   |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>214167533A</b>  |  | 17. INFORMANT<br><b>Eleanor Jimm</b>   |  | ADDRESS<br><b>542-0866</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>1509 squamous cell Cancer of Esophagus</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/10</b> , 19 <b>82</b> , to <b>1/8</b> , 19 <b>83</b> , that (I) (we) lost<br>saw the deceased alive on <b>12/10</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Dr. Nelson</b> MD   |  |  |  | 22c. DATE SIGNED<br><b>1/9/83</b>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>NOGES GEBREMARIAM</b>  |  |
| 22e. ADDRESS<br><b>4600 Lakewood Heights</b>   |  |  |  | 22f. ADDRESS  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/13/83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Vet. Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crownsville, Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leroy Dyeth &amp; Son</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 10 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canine</b>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12  
FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 1 4 9

REG. NO.

|   |                         |  |   |   |  |   |  |
|---|-------------------------|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>EMERSON W. MADAIRY</b>                 |                         |  | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>8</b> YEAR <b>83</b> |   |  | 2b. HOUR<br><b>2:27</b> P.M.  |  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH <b>09</b> DAY <b>19</b> YEAR <b>10</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.                                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                 |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Typographer</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>Maryland</b>   |                         | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST <b>Albert</b> MIDDLE <b>C.</b> LAST <b>Madairy</b> |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mae</b> MIDDLE <b>Wilhelm</b> LAST <b></b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES)  |  |   |  |
| 16b. SOCIAL SECURITY NO.<br><b>215-07-6414</b>                                |                         | 17. INFORMANT ADDRESS<br><b>E. James Madairy, 12810 Manor Rd. 21057</b>  |   |   |  |   |  |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RENAL FAILURE</b><br><b>4860</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pneumonia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) <b></b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|--|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/16</b> 19 <b>82</b> , to <b>1/8</b> 19 <b>83</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/1</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Elio Raul Norve</b>  |  |  |  | DEGREE   |  | 22c. DATE SIGNED<br><b>1/8/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ELIO RAUL NORVE</b>   |  |  |  | 22e. ADDRESS   |  |  |  |

|   |  |                             |  |   |  |  |  |
|---|--|-----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>1-12-83</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b> |  |
|---|--|-----------------------------|--|---|--|--|--|

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|--|--|--|--|--|--|
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b> |  | 25a. DATE RECD. BY REGISTRAR<br><b>JAN 10 1983</b> |  | 25b. REGISTRAR'S SIGNATURE<br><b>Elio Raul Norve</b> |  |
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RELEASED NON-MED DR. KORRELL PER MR. HENRI  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  | REG. NO.  |  |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 8 3 0 1 1 5 0  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>BABY BOY MADDEN</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 4, 1983</b>  |  | 2b. HOUR <b>7:29</b> P <b>M</b>   |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>Black</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 29, 1982</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>0</b> <b>7</b> MONTHS DAYS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>None</b>   |  |
| 13a. STATE <b>Md.</b>  |  | 13b. COUNTY <b>Baltimore</b>   |  | 13c. CITY OR TOWN <b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Gary Lewis</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Priscilla Ann Madden</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO. <b>None</b>   |  | 17. INFORMANT <b>Priscilla Madden Baltimore, Md. 21229</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>7469</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>CONGENITAL HEART DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>-</b> |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>IMMEDIATE</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><b>None</b>   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION <b>-</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 4</b> , 19 <b>83</b> , to <b>Jan 4</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>Jan 4</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                              |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>J. H. 8. PINHEIRO</b> DEGREE <b>MD</b>   |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED <b>1/4/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. H. 8. PINHEIRO</b>   |  |  |  | 22e. ADDRESS <b>JOHNS HOPKINS HOSPITAL - PEDIATRICS.</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>Jan. 8, 1983</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>St. Lukes Church Cem.</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Reisterstown, Balto. Co., Md.</b>  |  |
| 24. FUNERAL DIRECTOR <b>H. F. Eichhardt</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 11 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Joan J. Connel</b>  |  |
| Owings Mills, Md.  |  |  |  |  |  |   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 1 5 1

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |  |   |   |  |
|---|--|--|---|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>THERESA MAHLER</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 12 83</b> |   |  | 2b. HOUR<br><b>4:25 AM</b>  |   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAR. 23, 1910</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   |   |  |   |   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTO.</b>   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MAX MOSES</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>BECKY BERLIN</b>   |   |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217-58-7362</b>   |   | 17. INFORMANT<br><b>DR. IRVING F. MAHLER</b><br><b>3102 MARNAT RD. BALTO., MD 21208</b>   |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4300 IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASPIRATION PNEUMONIA VS SEPSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>LESION OF BERRY ANEURYSM</b>                  |  |  |   |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |   |   |  |   |   |  |
| 19a. DATE OF OPERATION<br><b>12/20/82</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>BERRY ANEURYSM</b>  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 19, 1982</b> , to <b>Jan 12, 1983</b> , that (I) (we) last saw the deceased alive on <b>Jan 12, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |   |   |  |
| 22b. SIGNATURE<br><b>Ruth L. Hilleeson MD</b>   |  |  |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>1/12/83</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RUTH L. HILLEESON</b>   |  |  |   | 22e. ADDRESS<br><b>SINAI HOSPITAL, BALTO, MD</b>  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>  |  | 23b. DATE<br><b>JAN. 13, 1983</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE HEBREW</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>REISTERSTOWN BALTO. MD</b>                     |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b><br>ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 18 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. G. Connel</b>   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.





CHIEF



STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8301152

 1- FOR  
 STATE  
 REGISTRAR

REG. NO.

|  |  |  |  |   |                             |  |  |
|--|--|--|--|---|-----------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Constance Mary Malczewski</i>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>1 4 83</i> |   | 2b. HOUR<br><i>11:40 AM</i> |  |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>White</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>5 3 30</i>   |                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>52</i> YRS.  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Balto., Md.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Baltimore City Hospitals</i> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Cook</i>   |                             | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Restaurant</i>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Maryland</i>  |  | 13b. COUNTY<br>-----   |  | 13c. CITY OR TOWN<br><i>Baltimore</i>   |                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Christian Walton</i>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Catherine Williams</i>   |  |   |                             |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>213-26-4745</i>   |  | 17. INFORMANT ADDRESS<br><i>Stephen Malczewski 905 S. Streeper St.</i>  |                             |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><i>1539</i> IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Metabolic Acidosis, Sepsis from Right leg Ulcer on 5 days</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Colon Cancer</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>6 minutes</i><br><i>3 yrs.</i> |  |  |  |   |                             |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |                             |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                             | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                             |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                             |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/1/82</i> , 19 <i>82</i> , to <i>1/1/83</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>1/1/83</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |                             |  |  |
| 22b. SIGNATURE<br><i>Robert Udelman</i>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                             |                             | 22c. DATE SIGNED<br><i>1/4/83</i>  |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Robert Udelman</i>   |  | 22c. ADDRESS<br><i>Baltimore City Hospital</i>   |  |   |                             |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>1-8-83</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>St. Stanislaus Cem.</i>  |                             | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore City, Md.</i>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>C.S. Zeiler &amp; Son Inc.</i>  |  | ADDRESS<br><i>901 S. Conkling Street</i>   |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><i>JAN 7 1983</i>   |                             |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 1 5 3

REG. NO.

|   |  |  |   |  |  |   |  |   |  |
|---|--|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Anthony Malone</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 18 83</b> |  |  | 2b. HOUR<br><b>M</b>  |  |   |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>Black</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 28 1899</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Kentucky</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                              |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1533 N. Pulaski Street</b> |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1533 N. Pulaski St. 21217</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert Malone</b>  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Hester Easley</b>  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>402-22-0757</b>  |   | 17. INFORMANT ADDRESS<br><b>Elizabeth Malone 1533 N. Pulaski St.</b>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>unknown</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>last</b>   |  |  |   |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12</b> 19 <b>82</b> , to <b>19</b> , that (I) (we) last saw the deceased alive on <b>1/11</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. |  |  |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Chi V. Dang</b>  |  |  |   | DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Chi V. Dang</b>   |  |  |   | 22e. ADDRESS<br><b>J. Hopkins Hospital</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>1/22/83</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>A4butus Md.</b>                                |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H Inc. 1101 E. North Avenue</b>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 19 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Joan J. Conner</b>   |  |   |  |

BP

[illegible]

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 1 5 4

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Philip George Manko</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 22, 1983</b>                      |   | 2b. HOUR<br><b>12:40P M</b>  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 22, 1953<sup>AR</sup></b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>29</b>  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Attorney</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Law</b>  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>  |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>         | 13e. STREET ADDRESS<br><b>1661 Forest Park Ave. 21207</b>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Myron Manko</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anne Mary Bayer</b>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>218-64-6436</b>  |   | 17. INFORMANT<br><b>Theresa Ann Manko</b> ADDRESS<br><b>1661 Forest Park Ave., Baltimore, Md. 21207</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b><br><b>2000</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Large Cell Histiocytic Lymphoma Involving</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Mediastinum With Metastasis</b> |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.   |   |   |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>January 18, 1983</b> to <b>January 22, 1983</b> , that (X) (we) lost saw the deceased alive on <b>January 22, 1983</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (old) (do not) view the body after death.  |   |   |   |   |  |
| 22b. SIGNATURE<br><b>Richard A. Lane</b>   |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>1/22/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Richard A. Lane, M.D.</b>  |   | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>Jan. 25, 1983</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Evergreen Mem. Gardens</b>                 |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Finksburg, Carroll, Md.</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Richard Owings Mills</b>  |   | ADDRESS<br><b>Maryland</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 26 1983</b>   |  |
|  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>   |   |   |  |

MEDICAL CERTIFICATION

0513 43-815

204

Veroff, J.

000557

U.E.A.

724.55.2



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ROBERT W. MANNING JR.</b>               |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 11, 1983</b> |   |  | 2b. HOUR<br>MIN.<br><b>12:40</b>  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 19 45</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>37</b>  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD</b>                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH CITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert Manning</b>                   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Helen Toran</b>  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |  | 16b. SOCIAL SECURITY NO.<br><b>212-42-8741</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Helen Jones 1627 E. Oliver St.</b>   |  |   |  |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**5712** **cardiorespiratory arrest**  
DUE TO, OR AS A CONSEQUENCE OF  
(b) **metabolic acidosis**  
DUE TO, OR AS A CONSEQUENCE OF  
(c) **liver failure**

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

**alcoholic cirrhosis**

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 15</b> , 19 <b>82</b> , to <b>Jan 11</b> , 19 <b>83</b> , that (I) (we) lost<br>saw the deceased alive on <b>Jan 11</b> , 19 <b>83</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Patricia A. Tewes</b>   |  | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br><b>1-11-83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Patricia A. Tewes</b>  |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital<br/>601 N. Broadway Baltimore Md</b>   |  |  |  |   |  |

|   |  |                             |  |   |  |   |  |
|---|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>1/15/83</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>       |  |                             |  | ADDRESS<br><b>1101 E. North Ave.</b>                            |  | 25a. DATE RECD. BY REGISTRAR<br><b>JAN 12 1983</b>                |  |
|   |  |                             |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John G. Smith</b>                |  |

1. *Adiantum* - 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Items #23c&23d Film G576 2/9/83 re STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 3 0 1 1 5 6  
1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO.

|  |   |   |  |  |  |
|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ETHEL M. MAPLE</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01 - 22 - 83</b>                     |  | 2b. HOUR<br>1:30 P.M.  |
| 3. SEX<br><b>F</b>   | 4. RACE<br><b>B</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 - 02 - 13</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.                              | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD.</b>             |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIVERSITY OF MARYLAND HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MARYLAND</b>  |   |   | 13b. COUNTY<br><b>BALTO. CITY</b>  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HARRY COM</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CARRIE DEMBY</b>           |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>UNKNOWN</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>216-05-6617</b>  | 17. INFORMANT<br>ADDRESS<br><b>Rosetta A. Lee 2912 W. Lafayette Avenue</b>     |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEPSIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>UNKNOWN</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b> |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>COMATOSE 2° TO HYPOXIC ENCEPHALOPATHY</b>   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/11</b> , 19 <b>82</b> , to <b>1/22</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1/22</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Jean Olson MD</b>   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>1/22/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JEAN OLSON MD</b>  |   | 22e. ADDRESS<br><b>U. OF MD. HOSPITAL<br/>22 S. GREENE ST.<br/>BALTIMORE, MD 21201</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>   | 23b. DATE<br><b>1/27/83</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Auburn Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H Inc. 1101 E. North Avenue</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 24 1983</b>   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                               |  |  |



100%  
COTTON

MADE IN U.S.A.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |  |  |   |   |   |  |   |  | REG. NO. 83 01157 |  |
|--|-------------------------|--|--|---|---|---|--|---|--|-------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ALFRED P. MARANO</b>  |                         |  |  |   |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <b>January 12, 1983</b>                                    |  | 2b. HOUR <b>10 PM</b>   |  |                   |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 30, 1965</b>   | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) YRS.<br><b>17</b> | IF UNDER 1 YR.<br>MONTHS DAYS<br><b>17</b>  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>10</b> | 2c. DATE PRONOUNCED DEAD<br><b>January 13, 1983</b>   |  | 2d. HOUR <b>10 PM</b>   |  |                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |   |  |                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6108 Buckingham Manor Drive</b> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Student</b>                 |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                   |  |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>6108 Buckingham Manor Dr.</b>                             |  |                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Philip S. Marano</b>  |                         |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lucille Calfa</b>   |   |   |  |   |  |                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS<br><b>Mr. Philip S. Marano same as # 13</b>   |   |   |  |   |  |                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>9551 IMMEDIATE CAUSE (a) Shotgun Wound To Brain</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>                         |                         |  |  |   |   |   |  |   |  |                   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                         |  |  |   |   |   |  |   |  |                   |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. January 12, 1983</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>12 gauge Shotgun Wound To Brain</b>                                     |   |   |  |   |  |                   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Home</b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>6108 Buckingham Manor Rd. Balt Md</b>   |   |   |  |   |  |                   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                         |  |  |   |   |   |  |   |  |                   |  |
| ACTUAL SIGNATURE<br><i>Charles F. ...</i>  |                         |  |  | TITLE (SPECIFY)<br><i>Deputy</i>  |   |   |  | MEDICAL EXAMINER  |  |                   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |                         |  |  | ADDRESS   |   |   |  |   |  |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                         | 23b. DATE<br><b>1/15/83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith Cem.</b>  |   |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>             |  |                   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. 1050 York Road</b>   |                         |  |  | 25a. DATE REC'D BY REGISTRAR<br><b>JAN 17 1983</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>John J. ...</i>  |  |   |  |                   |  |

MEDICAL CERTIFICATION

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |   |   |  |   |  |
|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ERCELL LEIPHOLZ MARGIE                                     |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 29, 1983                            |   | 2b. HOUR<br>4:45P.M.   |
| 3. SEX<br>Female   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>August 12, 1925   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>57 YRS.                              | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.              |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>6145 Parkway Drive |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>School Teacher | 12b. KIND OF BUSINESS OR INDUSTRY<br>Balto. Schools                     |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland |   |   | 13b. COUNTY<br>Baltimore   | 13c. CITY OR TOWN<br>Baltimore  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Michael Leipholz   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ruby Erskine                      |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-20-9131A   |  | 17. INFORMANT<br>ADDRESS<br>Amira V. Unver 6204 5th Ave. Pittsburg, Pa. |  |

|  |  |  |   |  |  |
|--|--|--|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Multiple Sclerosis</u><br>3400<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>22                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Heart failure</u>  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Mar 28</u> , 19 <u>87</u> , to <u>Jan 29</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>Jan 28</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |  |   |  |  |
| 22b. SIGNATURE<br><u>Frederick J. Vollmer M.D.</u> DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |  |   | 22c. DATE SIGNED<br>1-31-83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Frederick J. Vollmer, M.D.  |  |  | 22e. ADDRESS<br>6100 York Road  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |  | 23b. DATE<br>1-31-1983   | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland |
| 24. FUNERAL DIRECTOR<br>NAME<br>Ruck Towson Funeral Home, Inc. Towson, Maryland  |  |  | ADDRESS<br>1050 York Road<br>DATE REC'D BY REGISTRAR<br>JAN 31 1983<br>REGISTRAR'S SIGNATURE<br><u>John J. Gish</u> |  |  |

BP



James G. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

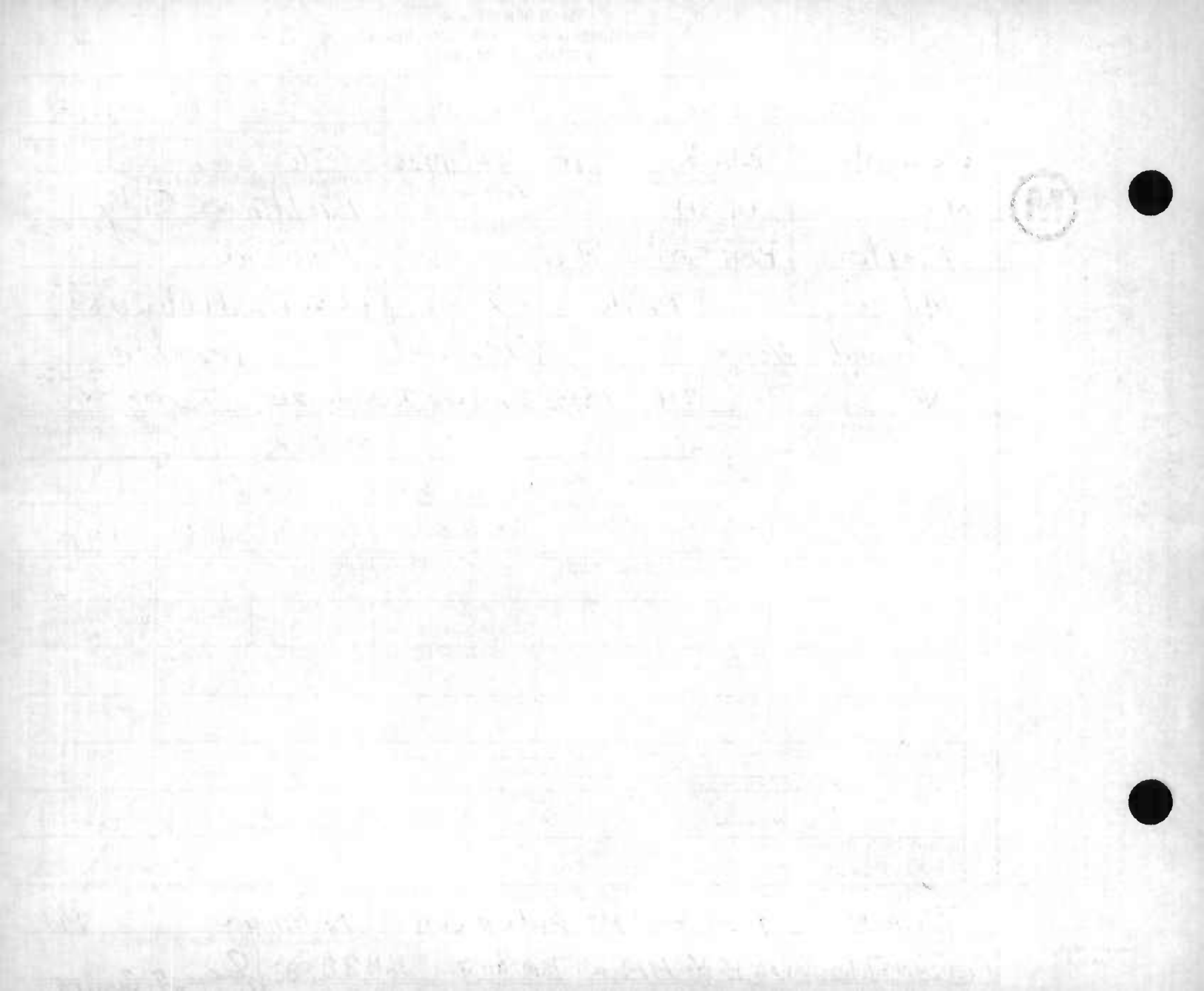
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP \_\_\_\_\_

DHMH: 16 30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |   |  |  |
|--|--|---|--|---|--|---|---|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   | 83 01159<br>REG. NO.   |   |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Rosella Marsh</b>  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1 25 83</b>                             |   |   |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>10 22 1926</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b> YRS                                  |   | 2b. HOUR<br><b>11:29</b> M   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD. N.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                 |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BON Secours Hosp.</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD</b>  |  |   |  |   | 13b. COUNTY<br><b>BALTO</b>  |   | 13c. STREET ADDRESS<br><b>62 S. Franklinton Rd</b>                |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Edward Howe</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Beulah Franklin</b>           |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  |   |  |   | 16b. SOCIAL SECURITY NO.<br><b>216-24-8892</b>                                 |   | 17. INFORMANT ADDRESS<br><b>Barbara Brown 2035 Booth St</b>       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4939</b> IMMEDIATE CAUSE (a) <b>Ac. Asthmatic attack</b>   |  |   |  |   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <div style="display: flex; justify-content: space-between;"> <div>             DUE TO, OR AS A CONSEQUENCE OF<br/>(b) <b>Hemorrhagic colitis</b><br/>             DUE TO, OR AS A CONSEQUENCE OF<br/>(c) <b>Hemorrhagic pleitis</b> </div> <div> <b>days</b><br/><br/><b>days</b> </div> </div> |  |   |  |   |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>   |  |   |  |   | DEGREE<br><b>MD</b>  |   |   | 22c. DATE SIGNED<br><b>1/25/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>THOMAS F. BROWN</b>  |  |   |  |   | 22e. ADDRESS<br><b>1940 W. Belk St Belk Md 21223</b>                           |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |   | 23b. DATE<br><b>1-29-83</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT AUBURN CEM</b>                     |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b> |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>BROWN-THOMPSON F. H.</b>   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 28 1983</b>                            |   |   |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |   |  |   |   |  |  |



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83

01160

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |  |  |   |
|---|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>GEORGE W. MARTIN</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 / 9 / 83</b>   |  | 2b. HOUR<br><b>7.40 P.M.</b>  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 9 14</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>68</b>   |  | IF UNDER 1 YEAR<br>IF UNDER 24 HRS.   |
| BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>North Charles General Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><b>MD</b>   |  |   | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>- - -</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Martin</b>  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>  | 17. INFORMANT<br>ADDRESS<br><b>Marvin Martin 2529 Garrett Avenue</b>   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Possible Septicemia &amp; shock</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Carcinoma of Prostate</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>1850</b>                             |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this Hospital) attended the deceased from <b>1/9 83</b> to <b>1/9 83</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/9 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) did (did not) view the body after death. |  |   |  |  |   |
| 22b. SIGNATURE<br><b>A.C. Chouvalit, M.D.</b>   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/9/83</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A.C. CHOUVALIT, M.D.</b>  |  |   | 22e. ADDRESS   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/14/83</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E. North Ave.</b>  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 11 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

BP



Handwritten text: *Handwritten text, possibly a date or reference number.*

Handwritten text: *Handwritten text, possibly a name or title.*

Handwritten text: *Handwritten text, possibly a small mark or symbol.*

Handwritten text: *Handwritten text, possibly a date or reference number.*

Handwritten text: *Handwritten text, possibly a date or reference number.*

Handwritten text: *Handwritten text, possibly a date or reference number.*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                  |  |  |  |  |  |  |  | REG. NO. 5301161  |  |
|--|--|------------------|--|--|--|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR<br>1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Jean Marie Martin   |  |                  |  |  |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>1 26 19 83  |  | 2b. HOUR<br>M<br>10:07 A   |  |   |  |
| 3- SEX<br>Female   |  | 4. RACE<br>White |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug 6 1954   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>28 YRS.   |  | IF UNDER 1 YR. MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                          |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital Shock Trauma |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Md   |  |                  |  | 13b. CITY OR TOWN<br>BALTO   |  | 13c. INSIDE CITY LIMITS<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  | 13d. STREET ADDRESS<br>55 Garden Ridge Rd 21228  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edward C Martin  |  |                  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret Ann Plant  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO  |  |                  |  | 16b. SOCIAL SECURITY NO.<br>None   |  | 17. INFORMANT ADDRESS<br>Margaret Martin - 55 Garden Ridge Rd  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>8147 IMMEDIATE CAUSE (a) Multiple Injuries<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |                  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |  |                  |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>8:35 PM 1 26 19 83  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>pedestrian struck by auto |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>street  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Eastbn Lane of Liberty Rd at Old Court, Balto. Md.    |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                  |  |  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE<br>H R Sharr  |  |                  |  | TITLE (SPECIFY)<br>M.D. Assistant  |  |  |  | DATE SIGNED<br>1/27/83   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Hormez R. Guard, M.D.   |  |                  |  | ADDRESS<br>111 Penn St., Balto., Md. 21201   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |                  |  | 23b. DATE<br>1-29-83   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem Pk   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Howard Co Maryland   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Farley - 6601 Frederick Ave  |  |                  |  |  |  | ADDRESS<br>21228   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 7 1983  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Calver  |  |

BP



03815





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 7/77  
(VR A 15 (4))

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 3 0 1 1 6 2  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR   |  |  |  | REG. NO.   |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>MARIE M MARTIN</b>   |  |  |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR   |  |
|  |  |  |  | 1 13 83  |  | 7 25 A M   |  |
| 3 SEX<br><b>FEMALE</b>   |  | 4 RACE<br><b>BLACK</b>   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |
|  |  |  |  | MONTH DAY YEAR   |  | IF UNDER 1 YEAR IF UNDER 24 HRS  |  |
|  |  |  |  | 10 17 94   |  | 88 YRS. MONTHS DAYS HOURS MIN.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>      |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PROVIDENT HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13e. STREET ADDRESS<br><b>3704 MOTTAWK AVENUE 21207</b>  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>RUBEN JACKSON</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LILLIAN LOGAN</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>199-18-3146</b>   |  | 17. INFORMANT<br><b>GERALDINE HACK-3704 MOTTAWK AVE. BALT. MD 21207</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PROBABLY DUE TO MASSIVE MI</b><br><b>OR PUL EMBOLISM</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>COMBINATION OF SURGICAL TRAUMA, GEN MEDICAL CONDITIONS</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>ACUTE MYOCARDIAL INFARCTION, LEFT ATRIAL FIBRILLATION, VASCULAR DISEASE, DM, LEFT HIP DISARTICULATION</b> |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/22</b> , 19 <b>82</b> , to <b>7/13</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1/13</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>C. Chinwura</b>   |  |  |  | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/13/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CHRISTIAN E. CHINWURA</b>  |  |  |  | 22e. ADDRESS<br><b>DEPT OF SURGERY PROVIDENT HOSPITAL BALTIMORE</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>1/16/83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BOWLING GREEN MEM. PK.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>WESTCHESTER, PENNA.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HERBERT E. NUTTER-3035 W. NORTH AVE. #2016</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 17 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>  |  |

Final Exam

DHMH - 16 50M 4/82  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>William Leroy MASON</b>   |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 18, 1983</b>                                  |  | 2b. HOUR<br><b>7:30a</b> M   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 31 36</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>46</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Interior Decorator</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1519 Madison Ave. #A-3</b> 21205   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Leroy Brown</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Mason</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>217-34-8721</b>  |  | 17. INFORMANT ADDRESS<br><b>Leroy Brown 576 Baker Street</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>1509<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Esophageal carcinoma-metastatic.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Severe malnutrition</b><br>DUE TO, OR AS A CONSEQUENCE OF                            |  |   |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>Sept. 22, 1982</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Esophageal Obstruction</b>   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>September 7, 1982</b> to <b>January 18, 1983</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>January 18, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>William Polito, MD</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><b>1/18/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>William Polito, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/22/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Zion cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md</b>                                  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Chatman-Harris 1701 McCulloh Street</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 21 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>   |  |  |  |

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

VISIT 161778373

|   |  |  |   |   |  |  |  |  |  |
|---|--|--|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HELEN MAY KATHIAS</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1/27/83</b> |   |  | 2b. HOUR<br><b>1133 AM</b>   |  |  |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>CAU</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 4 95</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b>   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>USA Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto City</b> MD.                        |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, CITY STREET ADDRESS)<br><b>SINAI Hosp</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>CITY OR TOWN<br><b>Md. Carroll Westminster</b>  |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>604 Boole Rd 21157</b>                                     |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>AA John Schaeffer</b>  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST LAST<br><b>AA Gertrude Brown</b>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WITH DATES)<br><b>NO</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Mildred Sittig 179 Willis St. 21157</b>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1749</b> IMMEDIATE CAUSE (a) <b>Cardiac arrest.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Ca deathment.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Understand arrest.</b> |  |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/27</b> , 19 <b>83</b> , to <b>1/27</b> , 19 <b>83</b> , that (I) (we) last<br>saw the deceased alive on <b>1/27/83</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>(above) (at time) (did) (did not) view the body after death.                         |  |  |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>E. Edward Brown</b>  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br><b>1/27/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>E. Edward Brown</b>   |  |  |   | 22e. ADDRESS<br><b>Sinai Hosp of Balto.</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>1-29-83</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>John Luther Miller</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Westminster Carroll Md</b>          |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Robert Kyle Prutts L. Westminster, Md.</b>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 31 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>                                  |  |  |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



John - Schaeffer  
in front of 211 Main St. 2nd floor

1-22-53 - John Schaeffer Miller, 211 Main St. 2nd floor  
John Schaeffer Miller, 211 Main St. 2nd floor



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 1 6 5

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |   |
|---|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JOHN D. MATTHEWS</b>                    |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 8, 1983</b>                                     |   | 2b. HOUR<br><b>11:08</b>                            |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept 11, 1914</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>North Carolina</b>                | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                 |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired Shoe Repairman</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY                   |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>5308 Hamlet Ave 21214</b> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Arthur Matthews</b>                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Veola Bailey</b>  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>290-09-3930</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs Maggie S Matthews Same</b>                                   |   |

## 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

## PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **cardio respiratory arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **pancreatic carcinoma**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

**10 min****11 months**

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

|   |  |  |  |
|---|--|--|--|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>JAN 3</u> , 19 <u>83</u> , to <u>JAN 8</u> , 19 <u>83</u> , that (I) <u>we</u> last saw the deceased alive on <u>1/9</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (do) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><b>Daryl Gress, MD</b>  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/8/83</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Daryl Gress</b>   |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>  |  |

|  |                             |   |   |
|--|-----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                     | 23b. DATE<br><b>1/12/83</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Baltimore Md</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b> |                             | 25a. DATE RECD. BY REGISTRAR<br><b>JAN 10 1983</b>    |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death, and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



661212

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|  |         |  |  |  |  |   |  |                            |  |  |  |          |  |
|--|---------|--|--|--|--|---|--|----------------------------|--|--|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE   |  | LAST                                      |  | 2a. DATE KNOWN<br>OF DEATH |  | <input checked="" type="checkbox"/> MONTH<br><input type="checkbox"/> DAY<br><input type="checkbox"/> YEAR |  | 2b. HOUR |  |
| Russell  |         | Matthews   |  | Jr.  |  |   |  | 1                          |  | 14   |  | 1983     |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)   |  | 7. IF UNDER 1 YR.                         |  | 8. IF UNDER 24 HRS.        |  | 9. DATE PRONOUNCED<br>DEAD   |  | 10. HOUR |  |
| male   | Black   | 1 31 25  |  | 57 YRS.  |  |   |  |                            |  | 1 14 1983  |  | 2:42P    |  |
| 11. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |         | 12. CITIZEN OF WHAT COUNTRY?   |  | 13. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 14. BALTIMORE CITY OR COUNTY OF DEATH     |  |                            |  |  |  |          |  |
| Maryland   |         | U.S.A.   |  |  |  | Baltimore City                            |  |                            |  |  |  |          |  |
| 15. CITY OR TOWN OF DEATH  |         | 16. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 17. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |  | 18. KIND OF BUSINESS<br>OR INDUSTRY       |  |                            |  |  |  |          |  |
| Baltimore  |         | 901 Edmondson Avenue   |  |  |  |   |  |                            |  |  |  |          |  |
| 19. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |         | 20. CITY OR TOWN   |  | 21. INSIDE CITY LIMITS?  |  | 22. STREET ADDRESS                        |  |                            |  |  |  |          |  |
| Maryland   |         | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 514 Fremont Ave. 21201                    |  |                            |  |  |  |          |  |
| 23. FATHER'S NAME  |         | 24. MOTHER'S MAIDEN NAME   |  | 25. INFORMANT  |  | 26. ADDRESS                               |  |                            |  |  |  |          |  |
| Robert   |         | Agnes  |  | Harriett Matthews  |  | 4506 Fairfax Rd.                          |  |                            |  |  |  |          |  |
| 27. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |         | 28. SOCIAL SECURITY NO.  |  | 29. DATE OF DEATH  |  | 30. DATE OF DEATH                         |  |                            |  |  |  |          |  |
| yes  |         | 218-12-0837  |  | 1/15/83  |  | 1/15/83                                   |  |                            |  |  |  |          |  |
| 31. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                             |         |  |  |  |  |   |  |                            |  |  |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |         |  |  |  |  |   |  |                            |  |  |  |          |  |
| 32. DATE OF OPERATION  |         | 33. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  | 34. AUTOPSY?   |  |   |  |                            |  |  |  |          |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |                            |  |  |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |                            |  |  |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on<br>death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |  |  |  |   |  |                            |  |  |  |          |  |
| ACTUAL<br>SIGNATURE  |         | TITLE (SPECIFY)  |  | DATE<br>SIGNED   |  |   |  |                            |  |  |  |          |  |
| Thomas D. Smith, M.D.  |         | M.D. Deputy Chief  |  | 1/15/83  |  |   |  |                            |  |  |  |          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |         | ADDRESS  |  | 35. DATE REC'D. BY REGISTRAR   |  | 36. REGISTRAR'S SIGNATURE                 |  |                            |  |  |  |          |  |
| Thomas D. Smith, M.D.  |         | 111 Penn St. Balto., Md.   |  | JAN 17 1983  |  | John J. Connel                            |  |                            |  |  |  |          |  |
| 37. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |         | 38. DATE   |  | 39. NAME OF CEMETERY OR CREMATORY  |  | 40. LOCATION<br>CITY OR TOWN COUNTY STATE |  |                            |  |  |  |          |  |
| BURIAL   |         | 1/20/83  |  | Md. Veteran Cem.   |  | Crownsville Md.                           |  |                            |  |  |  |          |  |
| 41. FUNERAL DIRECTOR<br>NAME   |         | ADDRESS  |  | 42. DATE REC'D. BY REGISTRAR   |  | 43. REGISTRAR'S SIGNATURE                 |  |                            |  |  |  |          |  |
| Wm.C. March F/H Inc.   |         | 1101 E. North Ave.   |  | JAN 17 1983  |  | John J. Connel                            |  |                            |  |  |  |          |  |



RECEIVED  
JUL 11 1961  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

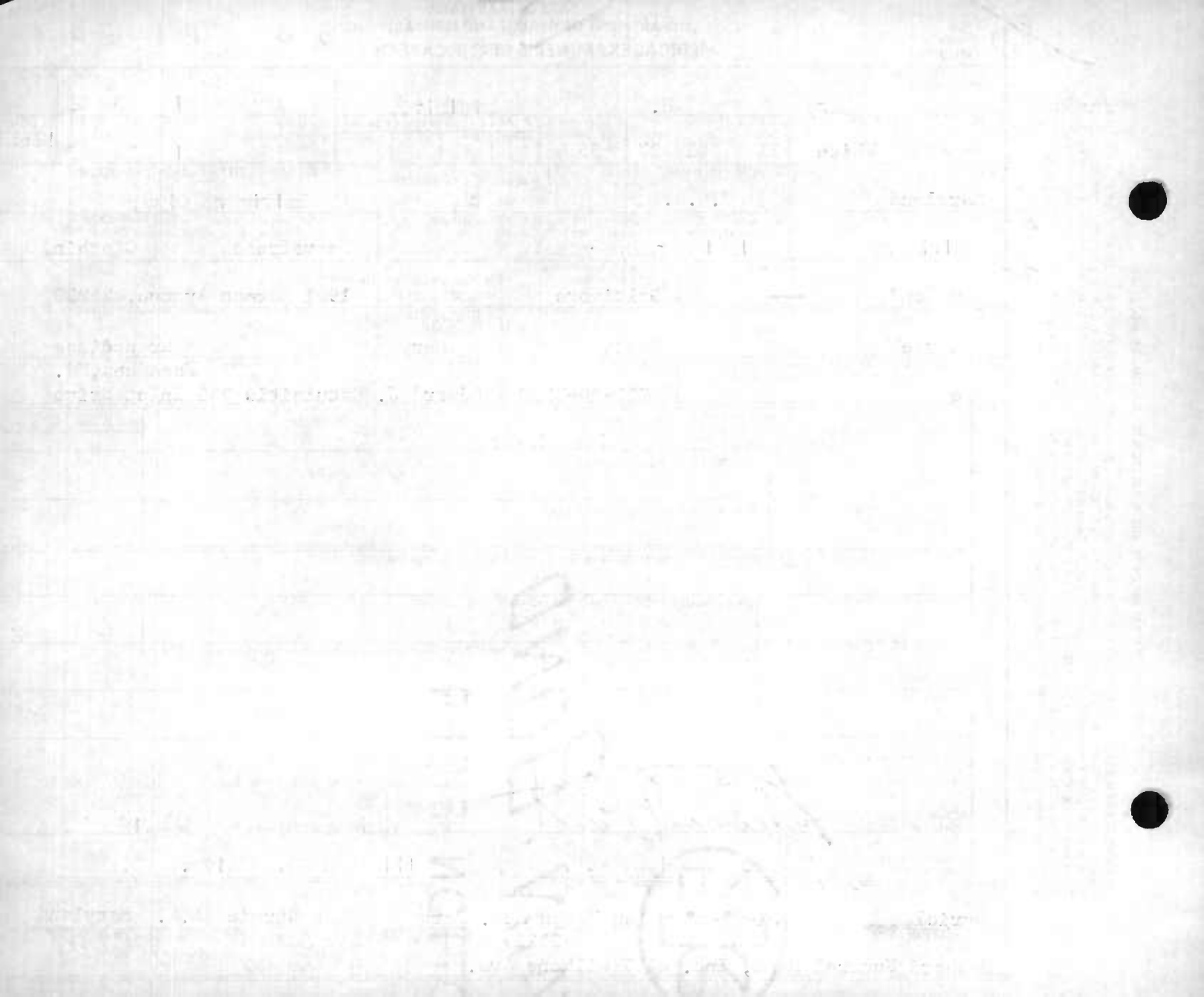


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM-PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |   |  | REG. NO. 01167                               |  |
|---|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Mary H. Matulaitis  |  |  |  |   |  | 2a. DATE KNOWN OF DEATH ESTIMATED<br>1 23 19 83   |  | 2b. HOUR<br>M   |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 02 27  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>55 YRS.   |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD<br>1 23 19 83       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                     |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1901 Harman Avenue |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Seamstress                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Clothing                                       |  |  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>---   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1901 Harman Avenue, 21230                                    |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Goetz  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Krancuinas  |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |  | (IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO.<br>220-20-8350   |  | 17. INFORMANT ADDRESS<br>Edward J. Matulaitis 243 Inlet Drive Pasadena, Md.                     |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>2019 IMMEDIATE CAUSE (a) Hodgkins Disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .<br>Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |  |  |   |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br>Thomas D. Smith, M.D.   |  |  |  | TITLE (SPECIFY)<br>Deputy Chief   |  |   |  | DATE SIGNED<br>1/24/83  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Thomas D. Smith, M.D.  |  |  |  | ADDRESS<br>111 Penn St. Balto., MD.   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>01-27-83  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem. Park  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Glen Burnie A.A. Maryland                         |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc.  |  |  |  | ADDRESS<br>4107 Wilkens Ave.  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 26 1983  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Lohr  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 83 01168  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  |  |   |  |
| I. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ADAM MAXWELL</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1 18 83</b>   |  | 2b. HOUR<br><b>2:15 PM</b>  |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>B</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>1 10 00</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>83</b> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Georgia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balti' Ct</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13e. STREET ADDRESS<br><b>2804 Violet Avenue 21215</b>  |  | 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Jermire Maxwell</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mattie</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> OR UNKNOWN <input type="checkbox"/> (IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO.<br><b>260-14-1214</b>   |  | 17. INFORMANT ADDRESS<br><b>Willie Maxwell 2804 Violet Avenue</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>3229 IMMEDIATE CAUSE (a) Probable Meningitis</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/27</b> , 19 <b>82</b> , to <b>1/18</b> , 19 <b>83</b> , that (I) (we) lost <b>view the deceased above on 1/18/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.  |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Adam Blacksin</b>  |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED<br><b>1/18/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ADAM BLACKSIN</b>   |  | 22e. ADDRESS<br><b>Lutheran Hosp. Md.</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>1/21/83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Auburn Cem.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>Wm. C. March F/H Inc. 1101 e. north Avenue</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 19 1983</b>  |  |   |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>  |  |   |  |

BP \_\_\_\_\_





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Bureau of Health with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8301169   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BARBARA A. MAYO</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 1, 1983</b>   |  | 2b. HOUR<br><b>3:55 MA</b>   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 27 51</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>31</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Home Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Samuel Harper</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Shirley Taylor</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218-56-0821</b>   |  | 17. INFORMANT ADDRESS<br><b>Milton A. Mayo, Jr. 1528 E. Baltimore st.</b>   |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b>   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>MINUTES</b>   |  |
| 2028<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |  |   |  | (b) <b>LYMPHOPROLIFERATIVE DISORDER</b>  |  |
|  |  |  |  |   |  | (c) _____  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>DEC. 22, 1982</b> to <b>JAN. 1, 1983</b> , that (I) (we) last saw the deceased alive on <b>JAN. 1, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><i>John Mannisi</i>  |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>1/1/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John Mannisi</b>   |  | MD   |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION<br/>100 N. BROADWAY, BALTIMORE, MD. 2123</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>   |  | 23b. DATE<br><b>1/7/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H Inc. 1101 E. North Avenue</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 6 1983</b>  |  |  |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Carver</i>   |  |  |  |



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Handwritten signature or initials.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 1 7 0

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JAMES A. MCCALLUM</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01 07 1983</b> |  |  | 2b. HOUR<br><b>3:35P</b>   |  |
| 3. SEX<br><b>M.</b>  |  | 4. RACE<br><b>negro</b>  |  | 5. DATE OF BIRTH<br><b>6/22/10</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72 YRS.</b>  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Beth Steel</b>                                      |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>BALTO</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13d. STREET ADDRESS<br><b>1438 N. Eden St 21213</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph McCallum</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY Chambers</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-07-4683</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Naomi McCallum 1438 N. Eden St</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOVASCULAR COLLAPSE</b><br><b>4599</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>OPEN HEART SURGERY</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ACUTE SEPTAL PERFORATION ATRII</b> |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Diabetes mellitus</b>  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>11/1/82</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Acute USD</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/1/82</b> to <b>11/7/82</b> , that (I) (we) lost saw the deceased alive on <b>11/7/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Timothy Hall</b>  |  |  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>1/7/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Timothy Hall</b>   |  |  |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/12/83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MD National</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>MD</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Locke Funeral Home 1304 N. Central Ave</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 10 1983</b>  |  |  |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of page 3 and file it in the file of the deceased. Page 4 should be filed in the file of the deceased. Page 5 should be filed in the file of the deceased. Page 6 should be filed in the file of the deceased. Page 7 should be filed in the file of the deceased. Page 8 should be filed in the file of the deceased. Page 9 should be filed in the file of the deceased. Page 10 should be filed in the file of the deceased. Page 11 should be filed in the file of the deceased. Page 12 should be filed in the file of the deceased. Page 13 should be filed in the file of the deceased. Page 14 should be filed in the file of the deceased. Page 15 should be filed in the file of the deceased. Page 16 should be filed in the file of the deceased. Page 17 should be filed in the file of the deceased. Page 18 should be filed in the file of the deceased. Page 19 should be filed in the file of the deceased. Page 20 should be filed in the file of the deceased. Page 21 should be filed in the file of the deceased. Page 22 should be filed in the file of the deceased. Page 23 should be filed in the file of the deceased. Page 24 should be filed in the file of the deceased. Page 25 should be filed in the file of the deceased. Page 26 should be filed in the file of the deceased. Page 27 should be filed in the file of the deceased. Page 28 should be filed in the file of the deceased. Page 29 should be filed in the file of the deceased. Page 30 should be filed in the file of the deceased. Page 31 should be filed in the file of the deceased. Page 32 should be filed in the file of the deceased. Page 33 should be filed in the file of the deceased. Page 34 should be filed in the file of the deceased. 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Page 53 should be filed in the file of the deceased. Page 54 should be filed in the file of the deceased. Page 55 should be filed in the file of the deceased. Page 56 should be filed in the file of the deceased. Page 57 should be filed in the file of the deceased. Page 58 should be filed in the file of the deceased. Page 59 should be filed in the file of the deceased. Page 60 should be filed in the file of the deceased. Page 61 should be filed in the file of the deceased. Page 62 should be filed in the file of the deceased. Page 63 should be filed in the file of the deceased. Page 64 should be filed in the file of the deceased. Page 65 should be filed in the file of the deceased. Page 66 should be filed in the file of the deceased. Page 67 should be filed in the file of the deceased. Page 68 should be filed in the file of the deceased. Page 69 should be filed in the file of the deceased. Page 70 should be filed in the file of the deceased. Page 71 should be filed in the file of the deceased. Page 72 should be filed in the file of the deceased. Page 73 should be filed in the file of the deceased. Page 74 should be filed in the file of the deceased. Page 75 should be filed in the file of the deceased. Page 76 should be filed in the file of the deceased. Page 77 should be filed in the file of the deceased. Page 78 should be filed in the file of the deceased. Page 79 should be filed in the file of the deceased. Page 80 should be filed in the file of the deceased. Page 81 should be filed in the file of the deceased. Page 82 should be filed in the file of the deceased. Page 83 should be filed in the file of the deceased. Page 84 should be filed in the file of the deceased. Page 85 should be filed in the file of the deceased. Page 86 should be filed in the file of the deceased. Page 87 should be filed in the file of the deceased. Page 88 should be filed in the file of the deceased. Page 89 should be filed in the file of the deceased. Page 90 should be filed in the file of the deceased. Page 91 should be filed in the file of the deceased. Page 92 should be filed in the file of the deceased. Page 93 should be filed in the file of the deceased. Page 94 should be filed in the file of the deceased. Page 95 should be filed in the file of the deceased. Page 96 should be filed in the file of the deceased. Page 97 should be filed in the file of the deceased. Page 98 should be filed in the file of the deceased. Page 99 should be filed in the file of the deceased. Page 100 should be filed in the file of the deceased.

WAS. S. DALL TO S. F.

RECEIVED

1883

WAS. S. DALL TO S. F.

1883

WAS. S. DALL TO S. F.

RECEIVED

SECTION 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 4/82  
(VRA 15, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as to cause of death.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 3 0 1 1 7 1  |  |  |  |
|---|--|--|--|--|--|--|--|
| FOR<br>STATE<br>REGISTRAR   |  |  |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>RAYMOND M McCARRELL</u>  |  |  |  | 2a. DATE OF DEATH  |  | 2b. HOUR   |  |
| FIRST MIDDLE LAST   |  |  |  | MONTH DAY YEAR   |  | 300A M   |  |
| 3. SEX<br><u>MALE</u>   |  | 4. RACE<br><u>CAUC</u>   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |
| MONTH DAY YEAR  |  | MONTHS DAYS HOURS MIN.   |  | 54 YRS   |  | IF UNDER 1 YEAR IF UNDER 24 HRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>ILLINOIS</u>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>BALTIMORE CITY</u> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><u>BALTIMORE CITY</u>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>UNIV. OF MARYLAND HOSP</u> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>ELECTRICIAN</u>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 13a. STATE<br><u>MD</u>   |  | 13b. COUNTY<br><u>BALTIMORE</u>  |  | 13c. CITY OR TOWN<br><u>BALTIMORE</u>  |  | 13e. STREET ADDRESS<br><u>954 FOREST STREET</u>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>STUART N McCarrell</u>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>ANNA H VANDERWALL</u>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><u>UNKNOWN</u>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><u>469-98-?</u>  |  | 17. INFORMANT<br><u>HOSPITAL CHART</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>HEPATIC FAILURE</u><br><u>1539</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>ADENO CARCINOMA OF COLON</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u>         |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><u>10/25/82</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>COLON CANCER</u>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>OCT 19</u> , 19 <u>82</u> , to <u>JAN 1</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>DEC 31</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Michael Hamilton MD</u>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>     |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>J. MICHAEL HAMILTON MD</u>  |  |  |  | 22e. ADDRESS<br><u>UNIV. OF MD HOSP, BALTIMORE MD</u>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Cremation</u>  |  | 23b. DATE<br><u>1-11-83</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Westview Crematory</u>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Balti. Md.</u>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>James A. Morton &amp; Sons</u>   |  |  |  | ADDRESS<br><u>1201 Hanover St.</u>   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>JAN 12 1983</u>  |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Conner</u>  |  |  |  |

BP

UNITED STATES DEPARTMENT OF THE ARMY  
OFFICE OF THE CHIEF OF STAFF  
WASHINGTON, D. C.



CHIEF OF STAFF

20% COLLECT





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed - within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| 1. DECEASED NAME<br>(TYPE OR PRINT)   |                              | FIRST | MIDDLE   | LAST | 2a. DATE OF DEATH  |  | MONTH           | DAY  | YEAR  | 2b. HOUR   |  |  |  |  |
|---|------------------------------|-------|--|------|--|--|-----------------|------|---|--|--|--|--|--|
| CATHERINE M. McCARTHY   |                              |       |  |      | 1/25   |  | 83              | 4:15 | PM  |  |  |  |  |  |
| 3. SEX  | 4. RACE                      |       | 5. DATE OF BIRTH   |      | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR |      | IF UNDER 74 HRS.  |  |  |  |  |  |
| FEMALE  | WHITE                        |       | 3 21 16  |      | 66   |  | MONTHS DAYS     |      | HOURS MIN.  |  |  |  |  |  |
| 7a. BIRTHPLACE<br>(COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY? |       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      | 9. BALTIMORE CITY OR COUNTY OF DEATH                                   |  |                 |      |   |  |  |  |  |  |
| MASS.   | USA                          |       |  |      | Baltimore city MD.   |  |                 |      |   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |                              |       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |      |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                 |      | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |  |  |
| Baltimore   |                              |       | Lutheran Hospital  |      |  | RETIRED  |                 |      | U.S. CIVIL SERV.  |  |  |  |  |  |
| 13a. STATE  |                              |       | 13b. COUNTY  |      |  | 13c. CITY OR TOWN  |                 |      | 13d. INSIDE CITY LIMITS?  |  |  |  |  |  |
| Maryland  |                              |       |  |      |  | BALTIMORE  |                 |      | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |
| 14. FATHER NAME   |                              |       |  |      | 15. MOTHER'S MAIDEN NAME   |  |                 |      |   |  |  |  |  |  |
| RICHARD W. McCARTHY   |                              |       |  |      | KATHERINE KELLY  |  |                 |      |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |                              |       |  |      | 16b. SOCIAL SECURITY NO.   |  |                 |      |   | 17. INFORMANT  |  |  |  |  |
| No  |                              |       |  |      | 578-32-5997  |  |                 |      |   | RITAMODLIN   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |                              |       |  |      | 19. DATE OF OPERATION  |  |                 |      |   | 20a. AUTOPSY?  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:  |                              |       |  |      | 1/18/83  |  |                 |      |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |  |  |  |
| IMMEDIATE CAUSE (a) Cardio-respiratory failure  |                              |       |  |      | 1991   |  |                 |      |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?              |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |                              |       |  |      | Metastatic Carcinoma.  |  |                 |      |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |                              |       |  |      | DUE TO, OR AS A CONSEQUENCE OF   |  |                 |      |   |  |  |  |  |  |
|   |                              |       |  |      | Pathological fracture. Fever   |  |                 |      |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                              |       |  |      | Metastatic carcinoma with Pathological fracture                        |  |                 |      |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |                              |       |  |      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |                 |      |   | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |  |
| 1/18/83   |                              |       |  |      | Pathological fracture of femur   |  |                 |      |   |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |                              |       |  |      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |                 |      |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |                              |       |  |      | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |                 |      |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/25/83 to 1/25/83, that (I) (we) lost saw the deceased alive on 1/25/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                              |       |  |      | 22b. SIGNATURE<br>Hyman MD   |  |                 |      |   | 22c. DATE SIGNED   |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |                              |       |  |      | 22e. ADDRESS   |  |                 |      |   |  |  |  |  |  |
| Sussman   |                              |       |  |      | Lutheran Hospital  |  |                 |      |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |                              |       |  |      | 23b. DATE  |  |                 |      |   | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  |
| BURIAL  |                              |       |  |      | 1/28/83  |  |                 |      |   | HOLY HOOD CEM.   |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME  |                              |       |  |      | 25a. DATE REC'D. BY REGISTRAR  |  |                 |      |   | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |
| E. BARNES   |                              |       |  |      | 21018 BENSON, MD.  |  |                 |      |   | JAN 26 1983  |  |  |  |  |
| FLEMING FUNERAL SERVICE   |                              |       |  |      |  |  |                 |      |   | John J. Connel   |  |  |  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



| FOR<br>1. STATE<br>REGISTRAR   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   | 8.3 01173<br>REG. NO.  |   |
|--|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   | MIDDLE  | LAST   | 2a. DATE OF DEATH<br>MONTH DAY YEAR             |
| MARGARET F. MCCARTIN   |  |   |   |  | 1 17 83 10:30 PM                                |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |   | 6. AGE (IN YEARS LAST BIRTHDAY)  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.    |
| Female   | White  | 11/21/07  |   | 75 YRS   |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |
| West Virginia  | USA  |   |   | BALTIMORE CITY MD.   |   |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY               |
| BALTIMORE  | UNION MEMORIAL HOSPITAL  |   | Housewife   |  |   |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE  |  | 13b. CITY OR TOWN   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS  |   |
| MD   |  | Baltimore   | YES   | 717 W. 34TH Street 21211   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |   | 16. ADDRESS  |   |
| Carlos R. Hooton   |  | Mary Etta Vance   |   | 21120  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |   | 17. INFORMANT  |   |
| no   |  | 234 12 8494   |   | Charles M. Woody 1756 Parsonage Rd, Parkton  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <u>Biliary Stint</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <u>Kidney's tumor</u>   |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><u>Cardiac arrest 3 days prior to death</u>  |  |   |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/17</u> , 19 <u>83</u> , to <u>1/17</u> , 19 <u>83</u> , that (I) (we) lost<br>saw the deceased alive on <u>1/17</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br><u>Carl Sperling MD</u>   |   | 22c. DATE SIGNED<br><u>1/17/83</u>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |   | 22f. DEGREE<br>MD  |   |
| CARL SPERLING, M.D.  |  | 201 E. UNIVERSITY PKWY BALTO 21218  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY   |   |
| Burial   |  | 1/21/83   |   | Meadowridge Mem. Pk  |   |
| 24. FUNERAL DIRECTOR<br>NAME   |  | 24b. ADDRESS  |   | 25a. DATE REC'D. BY REGISTRAR  |   |
| Burgee Funeral Home, 3631 Falls Road 21211   |  |   |   | JAN 19 1983  |   |
| 25b. REGISTRAR'S SIGNATURE   |  | 25c. REGISTRAR'S SIGNATURE  |   | 25d. REGISTRAR'S SIGNATURE   |   |
|  |  |   |   | John J. Conner   |   |



1938 JAN 18 1938

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8301174

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |
|--|--|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Charles William McClain   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 27 83  |   | 2b. HOUR<br>6:21A <sub>M</sub>  |
| 3. SEX<br>male   | 4. RACE<br>cauc  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 5 13   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Balto. Gen. Hosp. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Printer | 12b. KIND OF BUSINESS OR INDUSTRY<br>Sunpapers  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MD. |  | 13b. COUNTY<br>ANNE ARUNDEL   | 13c. CITY OR TOWN<br>PASADENA   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST Charles MIDDLE McClain LAST   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST Mary MIDDLE Anzel LAST  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                     |  | 16b. SOCIAL SECURITY NO.<br>213 03 2875   |   | 17. INFORMANT<br>Mildred McClain (same as 13e)  |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) cardiac arrest<br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) probable ventricular arrhythmia<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) atherosclerotic cardiovascular disease |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a   |  |  |

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/19 19 83 to 1/27 19 83, that (I) (we) last saw the deceased alive on 1/27 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE<br>J. Giles MD  |  | DEGREE   |  | 22c. DATE SIGNED<br>1/27/83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>S. Giles MD   |  | 22e. ADDRESS<br>5136H.   |  |  |  |

|  |                      |   |   |
|--|----------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                   | 23b. DATE<br>1/29/83 | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md. |
| 24. FUNERAL DIRECTOR<br>NAME Balto., Md. 21225<br>George J. Gonce F.H. 4001 Ritchie Hwy. |                      | 25a. DATE REC'D. BY REGISTRAR<br>FEB 1 1983               |   |
|  |                      | 25b. REGISTRAR'S SIGNATURE<br>John J. Carver              |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Charles W. ...

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NOTICE



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical investigation required.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   |   |   |  | 8301175   |  |
|---|---|---|---|--|---|--|
| 1. FOR STATE REGISTRAR  |   |   | REG. NO.  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>DEAN H. McConigley</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 16 83</b>   |  | 2b. HOUR<br><b>11:10 P.M.</b>                                   |  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>AUG. 17, 1912</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7. BIRTHPLACE (STATE OR FOREIGN)<br><b>KANSAS</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY</b> MD.                                  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTO. CITY HOSP.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>RETIRED</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY                               |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD.</b>  | 13b. COUNTY<br><b>BALTO.</b>  | 13c. CITY OR TOWN<br><b>BALTO.</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>625 S. CLINTON ST. 21224</b>                         |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>PATRICK Mc CONIGLEY</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY MALLING</b>  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR DATES)<br><b>YES I WWII</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>509-07-1943</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>LOUISE McCONIGLEY SAME 21224</b>                |   |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br><b>4275 IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 DAYS</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Richard Hodes</b>  |   | DEGREE<br><b>RICHARD Hodes, M.D.</b>  |   | 22c. DATE SIGNED<br><b>1/16/83</b>   |   | 22d. ADDRESS<br><b>Baltimore City Hospital</b>   |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>CREMATION</b>   |   | 23b. DATE<br><b>1-19-83</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WESTVIEW MEM.</b>                     |   | 23d. LOCATION<br>CITY OR TOWN COUNTY<br><b>BALTO. CO. MD</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>THOMAS J. SKARDA 2829 HUDSON ST.</b>   |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 18 1983</b>                            |   | 25b. REGISTRAR'S SIGNATURE<br><b>Jan J. Conish</b>   |

BP



JAN 1 1968



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please do not retain by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 1 7 6

|  |  |  |                   |   |  |  |  |  |  |
|--|--|--|-------------------|---|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  | 2a. DATE OF DEATH |   |  | 2b. HOUR   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | 2a. DATE OF DEATH |   |  | 2b. HOUR   |  |  |  |
| Benjamin Carlton McConnell Sr.   |  |  | Jan. 12, 1983     |   |  | 10 <sup>30</sup> PM  |  |  |  |
| 1. SEX   |  | 4. RACE  |                   | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  | 7. IF UNDER 1 YEAR   |  |
| Male   |  | White  |                   | Aug. 21, 1910   |  | 72 yrs.  |  | MONTHS DAYS HOURS MIN.   |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  | 10. MD.  |  |
| Pennsylvania   |  | U.S.A.   |                   |   |  | Baltimore City   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                  |                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |  |  |
| Baltimore  |  | Baltimore City Hospitals   |                   | Superintendent  |  | Construction   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. CITY OR TOWN  |                   | 13c. INSIDE CITY LIMITS?  |  | 13d. STREET ADDRESS  |  |  |  |
| Maryland   |  | Baltimore  |                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 6709 Thruway 21222   |  |  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |                   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.                                       |  | 17. INFORMANT  |  |
| John   |  | Ellen  |                   | No  |  | 179.16,2688  |  | Benjamin C/ McConnell, Jr.<br>66 King Charles Circle, Balto., Md. 21237  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:   |  | 19. IMMEDIATE CAUSE (a)  |                   | 20. DUE TO, OR AS A CONSEQUENCE OF  |  | 21. (b)  |  | 22. DUE TO, OR AS A CONSEQUENCE OF   |  |
| 4275   |  | Cardio-pulmonary arrest  |                   |   |  | pulmonary arrest (presumed embolus)                            |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |                   |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                         |  |  |                   |   |  |  |  |  |  |
| Chronic obstructive pulmonary disease  |  |  |                   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                   | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
|  |  |  |                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from   |  | Jan 10, 1983   |                   | to Jan 12, 1983   |  | that (I) (we) last saw the deceased alive on                   |  | Jan 12, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |
| 22b. SIGNATURE   |  | DEGREE   |                   | 22c. DATE SIGNED  |  |  |  |  |  |
| Bruce Kinoshian  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                   | 1/12/83   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |                   |   |  |  |  |  |  |
| Bruce Kinoshian  |  |  |                   |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE  |                   | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                     |  |  |  |
| Burial   |  | 1/15/1983  |                   | Queen of Peace Cem.   |  | Hawley Penna.  |  |  |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |                   | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |
| Walter Brooks Bradley, Inc. Dundalk Md. 21222  |  | JAN 17 1983  |                   | John J. Connel  |  |  |  |  |  |

MEDICAL CERTIFICATION

1911

1911



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 3 0 1 1 7 7   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LAWRENCE MCCRAY SR.</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01 28 1983</b>  |  | 2b. HOUR<br><b>12:05p</b>  |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 7 18</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64 YRS.</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S. Carolina</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Lucius McCray</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Eunice Bogkin</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>216-03-6085</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Donna M Wilkerson 1834 E. 29th St.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>7369</b><br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Probable Pulmonary Embolus</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Stroke post Right Amputation for gas gangrene</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><b>diabetic keto aci dosis</b>  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>11/27/83</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Gas gangrene</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/21/83</b> , 19 <b>83</b> , to <b>1/28</b> , 19 <b>83</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/28</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Victor V. Villanar</b>   |  |  |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/28/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Victor V. Villanar</b>  |  |  |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIES<br><b>BURIAL</b>   |  | 23b. DATE<br><b>2/2/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Calvary Cem</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H Inc. 1101 E. North ave.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 31 1983</b><br>25b. REGISTRAR'S SIGNATURE<br><b>John J. [Signature]</b>   |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |  |  |  |
|--|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Rev. Gus C. McCullum                |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 1 83 |   |  | 2b. HOUR<br>1:55 PM  |  |
| 1. SEX<br>male   |  | 4. RACE<br>Black  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 23 36   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>46 YRS.                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S. Carolina                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.      |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinai Hospital |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  |
| 13a. STATE<br>Maryland   |  |   |   | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Gus McCullum                     |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Edna Montgomery  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>250-54-0825  |   | 17. INFORMANT<br>ADDRESS<br>Grace M. McCullum 5701 Winner Avenue  |  |  |  |

|  |  |  |  |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u><br>4148<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>volume cardiomyopathy</u><br>(c) <u>chronic pulmonary disease</u> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|--|--|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>1/25 19 82 to 1/1 19 83  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/15</u> 19 <u>82</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Philip F. Brodowitz</u>   |  | DEGREE<br>M.D.   |  | ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/><br>PHYSICIAN DIRECTOR PHYSICIAN |  | 22c. DATE SIGNED<br>1/4/83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Philip F. Brodowitz, M.D.   |  | 22e. ADDRESS<br>2435 W. Belvedere Ave 21215                            |  |   |  |  |  |

|  |  |                     |  |   |  |   |  |
|--|--|---------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)<br>BURIAL                        |  | 23b. DATE<br>1/7/83 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cem. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. Md. |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H Inc. 1101 E. North Avenue |  |                     |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 6 1983           |  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Carney</u>             |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Philip F. Beards, MD, 21215 Belvedere Ave, 21215

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 1 7 9

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |  |  |  |  |   |  |
|---|--|---|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>JAISE  |  | MIDDLE  |  | LAST<br>MCDANIELS  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JANUARY 16, 1983          |  | 2b. HOUR<br>10:40p  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 2 1898  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS.                 |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>South Carolina   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD. |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF KNOWN, GIVE FULL STREET ADDRESS)<br>JOHNS HOPKINS HOSPITAL |  |   |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md. |  |   |  |   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Balto.                                      |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Chandler   |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Louvenia  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT<br>ADDRESS<br>Louvinia Dickey 1117 N. Lakewood Ave.   |  |  |  |  |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) DIC

DUE TO, OR AS A CONSEQUENCE OF

(c) widely metastatic gastric carcinoma

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

## PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

## MEDICAL CERTIFICATION

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION<br>NA   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>NA                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)<br>NA |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>NA |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>NA                              |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 12-27, 1982, to 1-16, 1983, that (we) last saw the deceased alive on 1-16, 1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (If we did not view the body after death). |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>Joseph S. Weinstein MD   |  |  |  | DEGREE<br>MD   |  | 22c. DATE SIGNED<br>1-16-83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Joseph S. Weinstein   |  |  |  | 22e. ADDRESS<br>Johns Hopkins Hospital   |  |   |  |

|  |  |                      |  |   |  |   |  |
|--|--|----------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                         |  | 23b. DATE<br>1/21/83 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., Md. |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Leroy O. Dyett 4600 Liberty Hgts. Ave. |  |                      |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 18 1983          |  |   |  |
|  |  |                      |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Canine          |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |  |   |                                   |  |
|--|--|---|--|--|--|--|---|-----------------------------------|--|
| FOR<br>STATE<br>REGISTRAR  |  |   |  |  | REG. NO. 8301180   |  |   |                                   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>SABUCE Mc DUFFLE   |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>1 18 83  |  |   |                                   |  |
| 3 SEX<br>FEMALE  |  | 4 RACE<br>BLACK   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>2 24 20  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS.                        |   | 7b. HOUR<br>6:40 P.M.             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>SOUTH CAROLINA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>US  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.        |   |                                   |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF DECEASED IN HOME, GIVE STREET ADDRESS)<br>PROVIDENT HOSPITAL |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)    |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>MARYLAND   |  | 13b. COUNTY<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>2216 PRESSTMAN ST. 21216                  |   |                                   |  |
| 14 FATHER'S NAME<br>PRESTON MIDDLE CHAVIS  |  |   |  |  | 15 MOTHER'S MAIDEN NAME<br>FANNIE MIDDLE LAST  |  |   |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.  |  | 17 INFORMANT ADDRESS<br>ANGELO CHAVIS 5619 CLEARSRING ROAD   |  |  |   |                                   |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ESOPHAGEAL VARICEAL BLEEDURE</u><br>5715<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>HEPATIC ENCEPHALOPATHY</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>CIRRHOSIS OF LIVER</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |  |  |  |   |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.  |  |   |  |  |  |  |   |                                   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |                                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/18 83</u> to <u>1/18 83</u> that (I) (we) last saw the deceased alive on <u>1/18 83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |  |   |                                   |  |
| 22b. SIGNATURE<br><i>[Signature]</i> MD  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  |  |   | 22c. DATE SIGNED<br>1/20/83       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>KUMTCHIEK   |  |   |  | 22e. ADDRESS<br>1230 DRUID HILL AVE  |  |  |   |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>1-24 83  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>WESTERN STAR CEMT.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND |   |                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>E.L. PHILLIPS 1721 N. MONROE ST.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 20 1983   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                 |   |                                   |  |

18

25-3-1

25-3-1

25-3-1

25-3-1

25-3-1

25-3-1

25-3-1

25-3-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 1 8 1

REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>William Davis McElroy</i>   |  |   | 2a. DATE OF DEATH<br>MONTH <i>1</i> DAY <i>19</i> YEAR <i>83</i> 2b. HOUR <i>12:06 P</i>            |  |  |
| 3. SEX<br><i>Male</i>  | 4. RACE<br><i>Cauc</i>   | 5. DATE OF BIRTH<br>MONTH <i>11</i> DAY <i>2</i> YEAR <i>08</i>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>74</i> YRS. MONTHS <i>1</i> DAYS <i>1</i> HOURS <i>1</i> MIN. |  |  |
| 7a. BIRTH PLACE<br>(STATE OR FOREIGN)<br><i>Maryland</i>   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A</i>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                                   |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN FACILITY, GIVE STREET ADDRESS)<br><i>South Baltimore General</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OR GIVE FOR MOST OF WORKING LIFE)<br><i>Retired</i>                  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <i>Maryland</i> 13b. COUNTY <i>Baltimore</i> 13c. CITY OR TOWN <i>Baltimore</i>   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>     | 13e. STREET ADDRESS<br><i>3002 St. Paul St.</i> 13f. ZIP CODE <i>21218</i> |  |
| 14. FATHER'S NAME<br>FIRST <i>William</i> MIDDLE <i>McElroy</i> LAST <i>McElroy</i>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <i>Margaret</i> MIDDLE <i>Beimschla</i> LAST <i>Beimschla</i>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <i>Unknown</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>215-07-7485</i>  |   | 17. INFORMANT<br>ADDRESS   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Septic Shock</i><br>4449 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Gangrene of right lower leg</i> 12/30/82<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Ischemia from arterial thrombosis right leg.</i> 12/28/82<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><i>Renal failure, Arteriosclerotic Vascular disease, Liver failure</i> |  |   |   |  |  |
| 19a. DATE OF OPERATION<br><i>12/27/82</i>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Left iliac arterial occlusion</i>  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   |  |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |  |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |  |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 22a. I certify that (1) this hospital attended the deceased from <i>Dec. 19, 1982</i> to <i>Jan. 19, 1983</i> , that (1) we last saw the deceased alive on <i>Jan. 19, 1983</i> , and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (1) we (we) did not view the body after death. |   |  |  |
| 22b. SIGNATURE<br><i>Lawrence R. Bell III</i>  |  | DEGREE  |   | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Lawrence R. Bell III</i>   |  | 22e. ADDRESS<br><i>3001 S. Hanover St., Baltimore, Md.</i>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Removal</i>   |  | 23b. DATE<br><i>1-26-83</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  | 24. FUNERAL DIRECTOR<br>NAME <i>Anatomy Board</i> ADDRESS <i>Balto., Md.</i>  |   |  |  |
| 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 28 1983</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Connel</i>   |   |  |  |

A-43/64



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 3 0 1 1 8 2   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Addie McKiver</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 1, 1983</b>   |  | 2b. HOUR<br><b>6:55 P.M.</b>   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 05 03</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Hartville, S. Car.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>unemp.</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>   |  | 13d. STREET ADDRESS<br><b>1417 Argyle Ave.</b> <b>21217</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Lawrence Allen</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>172 22 9256</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Joseph Eley 617 Ivanhoe St.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Cerebral Vascular Accident</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <b>November 30</b> , 19 <b>82</b> , to <b>January 1</b> , 19 <b>83</b> , that (b) (we) last saw the deceased alive on <b>January 1</b> , 19 <b>83</b> , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.         |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>R. Schroeder M.D.</b>   |  |   |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>1/1/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert Schroeder, M. D.</b>  |  |   |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/6/83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leroy O. Dyett 4600 Liberty Hgts. Ave.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 3 1983</b>  |  |  |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>   |  |  |  |

1000 Liberty Street, N.Y.

Bureau Baltimore, Md.

Re: (Baltimore) (Baltimore)

January 1

January 1, 1958

General Hospital

Cardiac Arrest

171 22 9256 Joseph Ely 617 Ivanhoe St.

Lawrence

Allen

M.

Police

Receiving General Hospital

Group

Baltimore City

USA

X

Female

Black

12 02 58

71

January 1, 1958

Active

White



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |                                      |  |  |  |                               |  |  |  |  |  |          |  |  |  |
|---|--|--|--|--|--|--------------------------------------|--|--|--|-------------------------------|--|--|--|--|--|----------|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 8 3 0 1 1 8 3  |  |  |  |                                      |  |  |  |                               |  |  |  |  |  |          |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST                                 |  | 2a. DATE OF DEATH  |  | MONTH                         |  | DAY  |  | YEAR   |  | 2b. HOUR |  |  |  |
| Robert  |  | c  |  |  |  | MCLARREN                             |  | January 12, 1983   |  |                               |  |  |  |  |  | 7:00a M  |  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)      |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS               |  |  |  |  |  |          |  |  |  |
| Male  |  | White  |  | 3 7 18   |  | 64                                   |  | YRS.   |  | MONTHS                        |  | DAYS   |  | HOURS  |  | MIN.     |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |  |  |                               |  |  |  |  |  |          |  |  |  |
| Texas   |  | U.S.   |  |  |  | Baltimore City MD.                   |  |  |  |                               |  |  |  |  |  |          |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |                                      |  |  |  |                               |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                        |  |          |  |  |  |
| Baltimore   |  | Maryland General Hospital  |  |  |  |                                      |  |  |  |                               |  | Management   |  | Aeronautics  |  |          |  |  |  |
| 13a. STATE  |  |  |  |  |  |                                      |  |  |  | 13b. CITY OR TOWN             |  | 13c. STREET ADDRESS  |  | 13d. INSIDE CITY LIMITS?                                 |  |          |  |  |  |
| Md.   |  |  |  |  |  |                                      |  |  |  | Pasadena                      |  | 1392 Tanyard Lane  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |  |  |  |
| 14. FATHER'S NAME   |  |  |  |  |  |                                      |  |  |  | 15. MOTHER'S MAIDEN NAME      |  |  |  |  |  |          |  |  |  |
| FIRST MIDDLE LAST   |  |  |  |  |  |                                      |  |  |  | FIRST MIDDLE LAST             |  |  |  |  |  |          |  |  |  |
| Arthur C. McLaren   |  |  |  |  |  |                                      |  |  |  | Ruth Brooks                   |  |  |  |  |  |          |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  |  |  |                                      |  |  |  | 16b. SOCIAL SECURITY NO.      |  | 17. INFORMANT ADDRESS  |  |  |  |          |  |  |  |
| No  |  |  |  |  |  |                                      |  |  |  | 550-12-0274                   |  | Vicki Buck 1392 Tanyard Lane Pasadena, Md.                     |  |  |  |          |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |                                      |  |  |  |                               |  |  |  |  |  |          |  |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |                                      |  |  |  |                               |  |  |  |  |  |          |  |  |  |
| IMMEDIATE CAUSE (a) Respiratory failure   |  |  |  |  |  |                                      |  |  |  |                               |  |  |  |  |  |          |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |                                      |  |  |  |                               |  |  |  |  |  |          |  |  |  |
| (b) Metastatic carcinoma of the LUNG  |  |  |  |  |  |                                      |  |  |  |                               |  |  |  |  |  |          |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |                                      |  |  |  |                               |  |  |  |  |  |          |  |  |  |
| (c)   |  |  |  |  |  |                                      |  |  |  |                               |  |  |  |  |  |          |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |                                      |  |  |  |                               |  |  |  |  |  |          |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |                                      |  | 20a. AUTOPSY?  |  |                               |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |          |  |  |  |
|   |  |  |  |  |  |                                      |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |                               |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |          |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY  |  |                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |                               |  |  |  |  |  |          |  |  |  |
|   |  |  |  | HOUR A.M. MONTH DAY YEAR   |  |                                      |  |  |  |                               |  |  |  |  |  |          |  |  |  |
|   |  |  |  | P.M. 19  |  |                                      |  |  |  |                               |  |  |  |  |  |          |  |  |  |
| 21d. INJURY OCCURRED  |  |  |  | 21e. PLACE OF INJURY   |  |                                      |  | 21f. LOCATION  |  |                               |  |  |  |  |  |          |  |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>   |  |  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |                                      |  | CITY OR TOWN COUNTY STATE  |  |                               |  |  |  |  |  |          |  |  |  |
| AT WORK   |  |  |  |  |  |                                      |  |  |  |                               |  |  |  |  |  |          |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from January 3, 19 83, to January 12, 19 83, that (we) lost saw the deceased alive on January 12, 19 83, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. |  |  |  |  |  |                                      |  |  |  |                               |  |  |  |  |  |          |  |  |  |
| 22b. SIGNATURE  |  |  |  |  |  |                                      |  |  |  | DEGREE                        |  |  |  | 22c. DATE SIGNED   |  |          |  |  |  |
| Eric Fisher   |  |  |  |  |  |                                      |  |  |  | MD                            |  |  |  | 1/12/83  |  |          |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  |  |                                      |  |  |  | 22e. ADDRESS                  |  |  |  |  |  |          |  |  |  |
| Eric Fisher, M.D.   |  |  |  |  |  |                                      |  |  |  | c/o Maryland General Hospital |  |  |  |  |  |          |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  | 23b. DATE  |  |                                      |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |                               |  | 23d. LOCATION  |  |  |  |          |  |  |  |
| Removal   |  |  |  | 1/13/83  |  |                                      |  |  |  |                               |  | CITY OR TOWN COUNTY STATE                                      |  |  |  |          |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |  |                                      |  |  |  | 25a. DATE REC'D. BY REGISTRAR |  |  |  | 25b. REGISTRAR'S SIGNATURE                               |  |          |  |  |  |
| NAME  |  |  |  |  |  |                                      |  |  |  | ADDRESS                       |  |  |  |  |  |          |  |  |  |
| Anatomy Board   |  |  |  |  |  |                                      |  |  |  | Balto., Md.                   |  |  |  | JAN 20 1983  |  |          |  |  |  |



January 12, 1932

Baltimore City

Harvard General Hospital

Respiratory failure

Acute cardiac failure of the right

January 12

January 12

Harvard General Hospital

Harvard General Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpages: Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |                     |  |                  |  |
|--|--|---|--|---|--|--|--|---------------------|--|------------------|--|
| 1. FOR STATE REGISTRAR   |  | 8 3 0 1 1 8 4   |  | REG. NO.  |  |  |  |                     |  |                  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | SOPHIE A. McLAUGHLIN  |  | LAST  |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR      |  | 2b. HOUR         |  |
| SOPHIE AGNES McLAUGHLIN  |  |   |  |   |  | 1 3 83   |  | 8:35 A              |  | M                |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  | IF UNDER 1 YEAR     |  | IF UNDER 24 HRS. |  |
| FEMALE   |  | White   |  | MONTH DAY YEAR<br>9 15 11   |  | 71 YRS   |  | MONTHS DAYS         |  | HOURS MIN        |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |                     |  |                  |  |
| MD.  |  | U.S.A.  |  |   |  | BALTIMORE CITY MD.   |  |                     |  |                  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |                     |  |                  |  |
| BALTIMORE  |  | SOUTH BALT GEN HOSP   |  | Checker   |  | Tie Factory  |  |                     |  |                  |  |
| 13a. STATE   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |                     |  |                  |  |
| MD.  |  | A. A. Brooklyn Pk.  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 1215 CHURCH ST.  |  | 21225               |  |                  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.                                       |  | 17. INFORMANT       |  | ADDRESS          |  |
| JOHN   |  | RADZISZEWSKI  |  | Helen   |  | 220 14 5858  |  | Richard McLaughlin, |  | 21225            |  |
|  |  |   |  |   |  |  |  | 604 Luther St.,     |  | Baltimore, Md.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) METASTATIC CANCER TO BRAIN<br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) LUNG CANCER<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>MARCH 1982 |  |   |  |   |  |  |  |                     |  |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |   |  |   |  |  |  |                     |  |                  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                     |  |                  |  |
|  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                     |  |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |                     |  |                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET   |  | CITY OR TOWN   |  | COUNTY              |  | STATE            |  |
| 22a. I certify that (I (this hospital) attended the deceased from 12/30, 1982, to 1/3, 1982, that (I/we) last saw the deceased alive on 1/3, 1982, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) did (did not) view the body after death.  |  |   |  |   |  |  |  |                     |  |                  |  |
| 22b. SIGNATURE   |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED   |  |                     |  |                  |  |
| Maureen L. Durkin  |  |   |  |   |  | 1/3/83   |  |                     |  |                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  |   |  |  |  |                     |  |                  |  |
| MAUREEN L. DURKIN  |  | SOUTH BALT. GEN HOSP, BMT, MD.  |  |   |  |  |  |                     |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN                                  |  | COUNTY              |  | STATE            |  |
| Burial   |  | Jan. 5, '83   |  | Holy Cross Cemetery   |  | Brooklyn Pk., A.A.Co.,   |  | Maryland            |  |                  |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                                     |  |                     |  |                  |  |
| George J. Gonce,   |  | 4001 Ritchie Hg., Baltimore, Md.  |  | JAN 6 1983  |  | John J. Connel   |  |                     |  |                  |  |

BP



## CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |  |   |  |  |  |
|---|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Minnie Mebus</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Jan 9, 83</b> |   |  | 2b. HOUR<br><b>7 A. M.</b>  |  |  |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12-29-08</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b>  |  | 7. UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Luthern Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>NONE</b>                 |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD.</b>  |  | 13b. COUNTY<br><b>-</b>  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>21207 6811 CAMPFIELD RD</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>late Walter Seipp</b>  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>late Ray Mitnick</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  |  |   | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS<br><b>Augusburg Luthern Home 6811 Campfield RD</b>                        |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sepsis</b><br><b>5990</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>UTI</b><br>(c) <b>CVA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <b>11-18-82</b> , 19 <b>82</b> , to <b>Jan 1, 83</b> , 19 <b>83</b> . That (b) (we) lost above, (c) (we) (did) (did not) view the body after death.  |  |  |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Sissat Awore</b>   |  |  |   | DEGREE<br><b>MD</b>   |  |   |  | 22c. DATE SIGNED<br><b>Jan 9, 83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Sissat Awore</b>  |  |  |   | 22e. ADDRESS<br><b>Luthern Hospital</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>Jan 10'83</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Howard, Maryland</b>                           |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Harry H Witzke 4112 COLUMBIARd Ellicott City</b>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 11 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

M

MEDICAL CERTIFICATION



1950 May 15

1950 May 15

1950 May 15

1950

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 1 8 6

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |   |                                   |  |
|---|--|---|--|---|--|---|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Franklin L. Meeder, Sr.</b>             |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 15, 1983</b>         |   | 2b. HOUR<br><b>8:00 A.M.</b>   |   |                                   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 8, 1902</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.                 |                                   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD. |                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2817 Christopher Ave.</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Electrician</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS<br><b>2817 Christopher Ave. 21214</b>         |                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank J. Meeder</b>                  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Matilda Stagge</b> |   |  |   |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |  |   | 16b. SOCIAL SECURITY NO.<br><b>051-01-8972</b>                         |   | 17. INFORMANT<br>ADDRESS<br><b>Ethel Meeder 2817 Christopher Ave.</b>                  |   |                                   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

1629

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) **Small Bow Metastasis**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Stomach Cancer**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/> CAUSE OF DEATH |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK               |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (1) this hospital attended the deceased from above, (1) (we) (did) (did not) view the body after death.                      |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Donald W. Mintzer, M.D.</b>   |  | DEGREE<br><b>M.D.</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>Jan 17 1983</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS<br><b>3009 Evergreen Ave. Baltimore, Maryland</b>         |  |  |  |   |  |

|  |  |                                   |  |   |  |   |  |
|--|--|-----------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                            |  | 23b. DATE<br><b>Jan. 18, 1983</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial Park</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck, Inc. Baltimore, Maryland</b> |  |                                   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 18 1983</b>                 |  |   |  |
|  |  |                                   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                 |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



5

16

11

11089

11089

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8301187

REG. NO.

|  |  |   |  |   |   |   |  |   |  |  |
|--|--|---|--|---|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARY T. Meehling</b>  |  |   | 20. DATE OF DEATH MONTH DAY YEAR<br><b>1/23/83</b>                                   |   |   | 20. HOUR<br><b>4:58 AM</b>  |  |   |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 12, 1913</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mary Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>5001 Walther Ave. 21214</b>   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph McCartney</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Freda Hillman</b>                |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>               |  |   | 16b. SOCIAL SECURITY NO.<br><b>214-18-1193</b> |  |
| 17. INFORMANT<br><b>Helen M. Meehling</b>  |  |   | ADDRESS<br><b>5001 Walther Ave.</b>  |   |   | 21214   |  |   |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>5319</b> IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>in association w/</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>infarction of greater vessel</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |  |   |   |   |  |   |  |  |
| 19a. DATE OF OPERATION<br><b>1/23/83</b>   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Infarct of Greater Vessel</b> |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                    |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/22</b> , 19 <b>83</b> , to <b>1/23</b> , 19 <b>83</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/23</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>C. Gerald J. Scott</b>  |  |   |  |   |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>1/23/83</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. Gerald J. Scott</b>   |  |   |  |   |   | 22e. ADDRESS<br><b>Mary Hospital</b>  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>Jan 26 1983</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b> |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc.</b>   |  |   |  |   |   | ADDRESS<br><b>Baltimore, Maryland</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 24 1983</b>   |  |  |
|  |  |   |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>   |  |   |  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 1 8 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |   |   |   |   |  |
|--|--|---|--|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Kathryn - mensh</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 28 83</b>                  |   |   | 2b. HOUR<br><b>1/25</b> M   |   |   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 XX 1900</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNSYLVANIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto City</b> MD.   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LEVINDALE HEBREW HOME</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>                          |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |   | 13b. COUNTY<br><b>BALTIMORE</b>  |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>               |   | 13e. STREET ADDRESS<br><b>3121 BANCROFT RD. #21215</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>LOUIS SOLSKY</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SARAH UNKNOWN</b>  |   |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b> |   |   |  |
| 16a. SOCIAL SECURITY NO.<br><b>218-32-0713</b>   |  |   | 17. INFORMANT<br><b>MRS. BEVERLY SHARE</b>                             |   |   | 2447 FOREST GREEN RD #21209   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic obstructive lung disease</b><br><b>4960</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b> yrs.</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |   |   |   |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                 |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>1/27 19 83</b> to <b>6/16 19 81</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.   |  |   |  |   |   |   |   |   |  |
| 22b. SIGNATURE<br><b>Stevenson</b>   |  |   | 22c. ADDRESS<br><b>MD</b>  |   |   | 22d. DATE SIGNED<br><b>1/28/83</b>  |   | 22e. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22f. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>S. LEVENSON</b>  |  |   | 22g. ADDRESS   |   |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |   | 23b. DATE<br><b>1-30-83</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GREATER BALTO. LODGE</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD</b> |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SOL LEVINSON &amp; BROS., INC.<br/>6010 REISTERSTOWN RD., BALTO., INC. 21215</b>  |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 1 1983</b>  |   |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>  |  |   |  |   |   |   |   |   |  |

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 1 8 9

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |   |  |  |
|---|--|--|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARY C. MERRIMAN</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-3-83</b> |   |  | 2b. HOUR<br><b>4:00 AM</b>  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug 28, 1930</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>52</b> YRS                                      |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                    |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3900 Hudson Street</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Home maker</b> |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS<br><b>3900 Hudson Street 21224</b>                                |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Michael Trombetta</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Clara Quandt</b>  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>220-24-7523</b>   |  | 17. INFORMANT ADDRESS<br><b>James Merryman 3900 Hudson St. 21224</b>  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY ARREST</b><br><b>1830</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MELASTATIC OVARIAN CANCER</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):   |  |  |  |   |  |   |  |  |
| 19a. DATE OF OPERATION<br><b>June 1982</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Colostomy bowel obstruction due to cancer</b>                                   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>DECEMBER 1980</b> to <b>JAN 3 1983</b> , that (we) last saw the deceased alive on <b>December 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.  |  |  |  |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Michael B. Dillon MD</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>3 Jan 83</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MICHAEL B. DILLON MD</b>  |  |  |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Jan 6, 83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holly Hills Cem</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Co., Md.</b>                  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Dippel Funeral Homes, Inc.</b>   |  |  |  | ADDRESS<br><b>7110 Belair Road<br/>Baltimore, Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 5 1983</b>                                    |  |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>   |  |   |  |  |

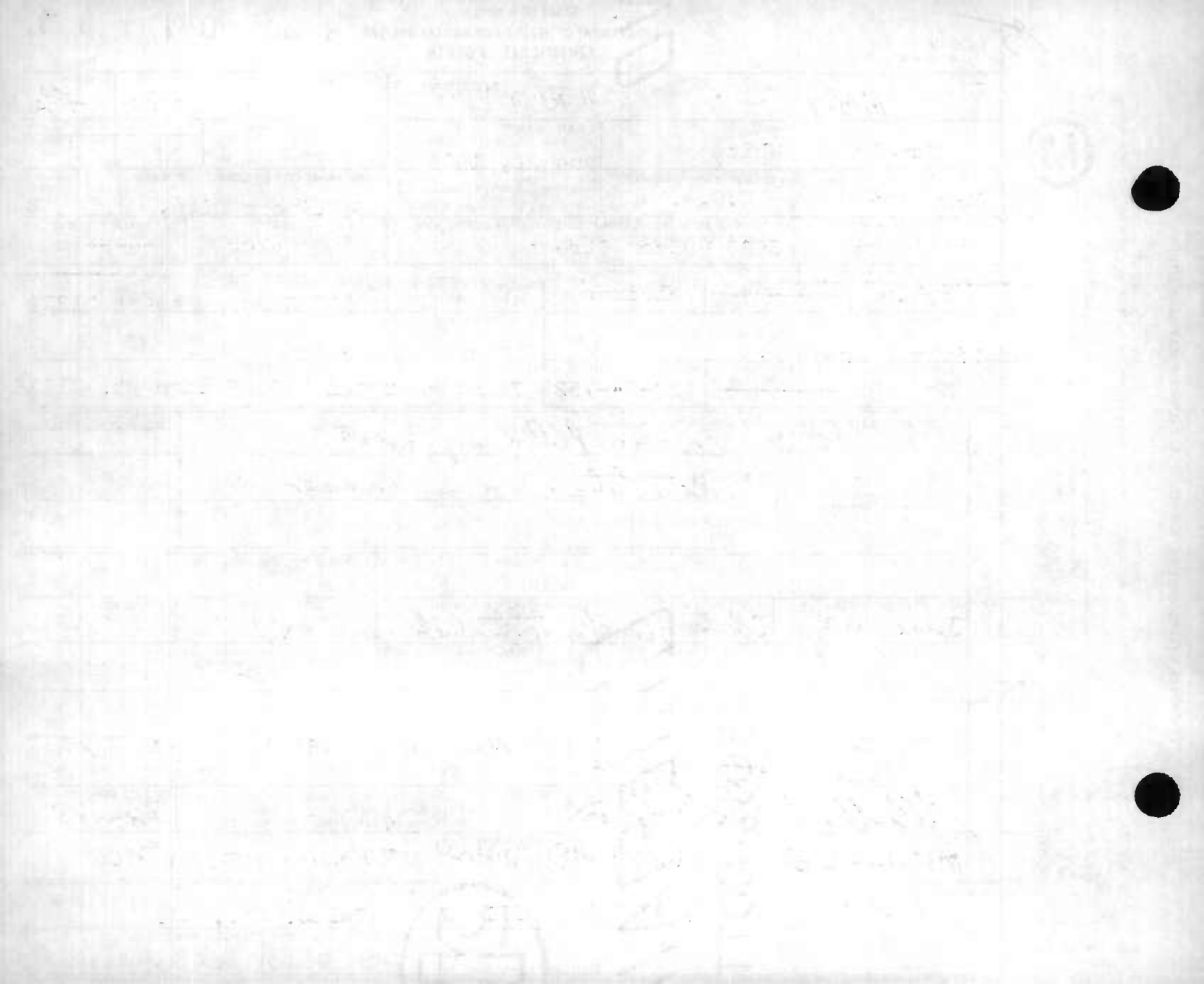
MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by a physician.

5

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 1 9 0

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>WILLIAM HOWARD MERVILLE   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1/17/83  |  | 2b. HOUR<br>6 P. M.  |
| 3. SEX<br>MALE  | 4. RACE<br>WHITE   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 3 03   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>W. VA.   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIVERSITY HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Conductor (R.T.)            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Bto R.R.                    |
| 13a. STATE<br>W. VA.  | 13b. COUNTY<br>WOOD  | 13c. CITY OR TOWN<br>PARKERSBURG  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>1811 Plum ST. 26101   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ALONZO MERVILLE   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>VIOLET REED  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO NONE   |  | 16b. SOCIAL SECURITY NO.<br>234-05-8662   |   | 17. INFORMANT<br>JANE FLINN (DAUGHTER)<br>ADDRESS<br>Box 371 BAY DR.<br>DRUM POINT LUSBY MD. 20657 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>4310 IMMEDIATE CAUSE (a) INTRACEREBRAL HEMORRHAGE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) MALIGNANT HYPERTENSION<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 DAYS<br>41 DAYS |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>ABDOMINAL AORTIC ANEURYSM, CORONARY ARTERY DISEASE, LUNG CA, PROSTATIC CA.  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/10 19 83, to 1/17 19 83, that (I) (we) lost<br>saw the deceased alive on 1/17 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (If (we) did not view the body after death, so state.)  |  |   |   |  |  |
| 22b. SIGNATURE<br>W. Howard Merville  |  | DEGREE  |   | 22c. DATE SIGNED<br>1/17/83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GU ARNAUD  |  | 22e. ADDRESS<br>UNIVERSITY HOSPITAL<br>22 S. GREENE ST. 21201   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>1-21-83  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>MOUNT OLIVET   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>PARKERSBURG WOOD W. VA.   |  |   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME E BARNES<br>FLEMING FUNERAL SERVICE  |  | ADDRESS<br>21048<br>Benson, Md  |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 18 1983   |  |
| 25b. REGISTRAR'S SIGNATURE<br>John J. Carver  |  |   |   |  |  |



20% COTTON

100% COTTON



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 1 9 1

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Mary F. Mettee  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 5 1983   |   | 2b. HOUR<br>P M<br>2:10 P  |  |
| 3. SEX<br>Female  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 2 1906  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                     |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3740 Bonview Avenue |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>- |
| 13a. STATE<br>Md.   | 13b. COUNTY<br>-   | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>2802 Kentucky Ave. 21213                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Orie Adkins   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Bess Montgomery  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>212-03-0708   |   | 17. INFORMANT<br>ADDRESS<br>Joan Mettee 3740 Bonview Ave.                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>2030 IMMEDIATE CAUSE (a) Multiple myeloma<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept. 4, 1982 to Oct. 29, 1982, that (I) (we) last saw the deceased alive on Oct. 29, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.             |  |   |   |  |  |
| 22b. SIGNATURE<br>Dr. Feldman   |  | DEGREE<br>MD  |   | 22c. DATE SIGNED<br>1/6/83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Feldman  |  | 22e. ADDRESS<br>302 Greenspring Station   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>1/7/83   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley                           |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.  |  | 24. FUNERAL DIRECTOR<br>Sofimunek Funeral Home, Inc.<br>3331 Brehms Lane, Balto. Md. 21213  |   |  |  |
| 25a. DATE REC'D. BY REGISTRAR<br>JAN 7 1983   |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Connel  |   |  |  |

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*Handwritten text, possibly a signature or date, appearing as "18/11/11" or similar.*

*Handwritten text, possibly a date or initials, appearing as "18/11/11".*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |   |  |   |
|--|---|---|---|--|---|
| 1. FOR<br>STATE<br>REGISTRAR   |   | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   | 8 3 0 1 1 9 2  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   | 2a. DATE OF DEATH   |   | 2b. HOUR   |   |
| FIRST MIDDLE LAST<br>Willbert Midgett  |   | MONTH DAY YEAR<br>01-28-83  |   | 5 04 A M   |   |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR                                    |
| M  | B   | MONTH DAY YEAR<br>07-14-22  | 60 YRS.   |  | IF UNDER 24 HRS.<br>HOURS MIN.                        |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |
| NC   | USA   |   |   | Balto. City MD   |   |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |  | 12b. KIND OF BUSINESS OR INDUSTRY                     |
| Balto. City  | Univ. of Md. Hosp.  |   | longshoreman  |  | shipping  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   | 13b. CITY OR TOWN   | 13c. INSIDE CITY LIMITS?  | 13d. STREET ADDRESS  |   |
| 13a. STATE   |   | Balto   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 1002 N. Woodington Rd. #1229   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |   |  |   |
| Dennis Midgett   |   | Callie N. Newton  |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS  |   |
| NO   |   | 221-12-5428   |   | Rosa Midgett 1002 Woodington Rd.   |   |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>respiratory failure</u><br>1893 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>metastatic urethral cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>mins. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |   |   |   |  |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?  |   |
|  |   |   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from above (I) (we) (did) (did not) view the body after death.   |   | 1/28/83 to 1/28/83  |   | that (I) (we) lost   |   |
| 22b. SIGNATURE<br>K. Robie Suh   |   | DEGREE  |   | 22c. DATE SIGNED<br>1/28/83  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robie - Suh   |   | 22e. ADDRESS<br>Univ. of Md. Hosp.  |   | (Balto, MD)  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |   | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE            |
| Burial   |   | 2/3/83  | Kings Park  |  | Randallstown Md.                                      |
| 24. FUNERAL DIRECTOR<br>NAME   |   |   | 25a. DATE REC'D. BY REGISTRAR                                       |  | REGISTRAR'S SIGNATURE                                 |
| Chas.A.Rice FSPA 1300 Eutaw Place  |   |   | JAN 31 1983   |  | John J. Carver  |

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 1 9 3

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |   |
|---|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MATTHEW MIKLEWSKI</b>                   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 1, 1983</b>                            |   | 2b. HOUR<br><b>12:27pm</b>                                |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 7 1915</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ohio</b>                          | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church home &amp; Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Self-Employed</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Grocer</b>        |
| 13a. STATE<br><b>MD.</b>  |  | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                 | 13e. STREET ADDRESS<br><b>2330 E. Fairmount Ave 21224</b> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank Miklewski</b>                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Antoinette Lewindowski</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |  | 16b. SOCIAL SECURITY NO.<br><b>277 12 3827</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Helena Miklewski 2330 E. Fairmount Ave</b>                                       |   |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY:<br><b>4100</b><br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>ACUTE INJECT WALL</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(c) <b>DIRECT POSTERIOR MYOCARDIAL INFARCTION</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>DECEMBER 26, 1982</b> to <b>JANUARY 1, 1983</b> , that (I) (we) lost<br>saw the deceased alive on <b>JANUARY 1, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE<br><b>T. Kawaja</b>   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/1/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>T. KAWAJA MD</b>   |  | 22e. ADDRESS<br><b>CHURCH HOME CORP.<br/>100 N. BROADWAY BALTIMORE, MD: 21231</b>  |  |  |  |

|   |                            |   |  |
|---|----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                           | 23b. DATE<br><b>1-5-83</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Stanislaus</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John M. Weber &amp; Sons Inc. 401 S. Chester ST.</b> |                            | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 4 1983</b>          | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                      |

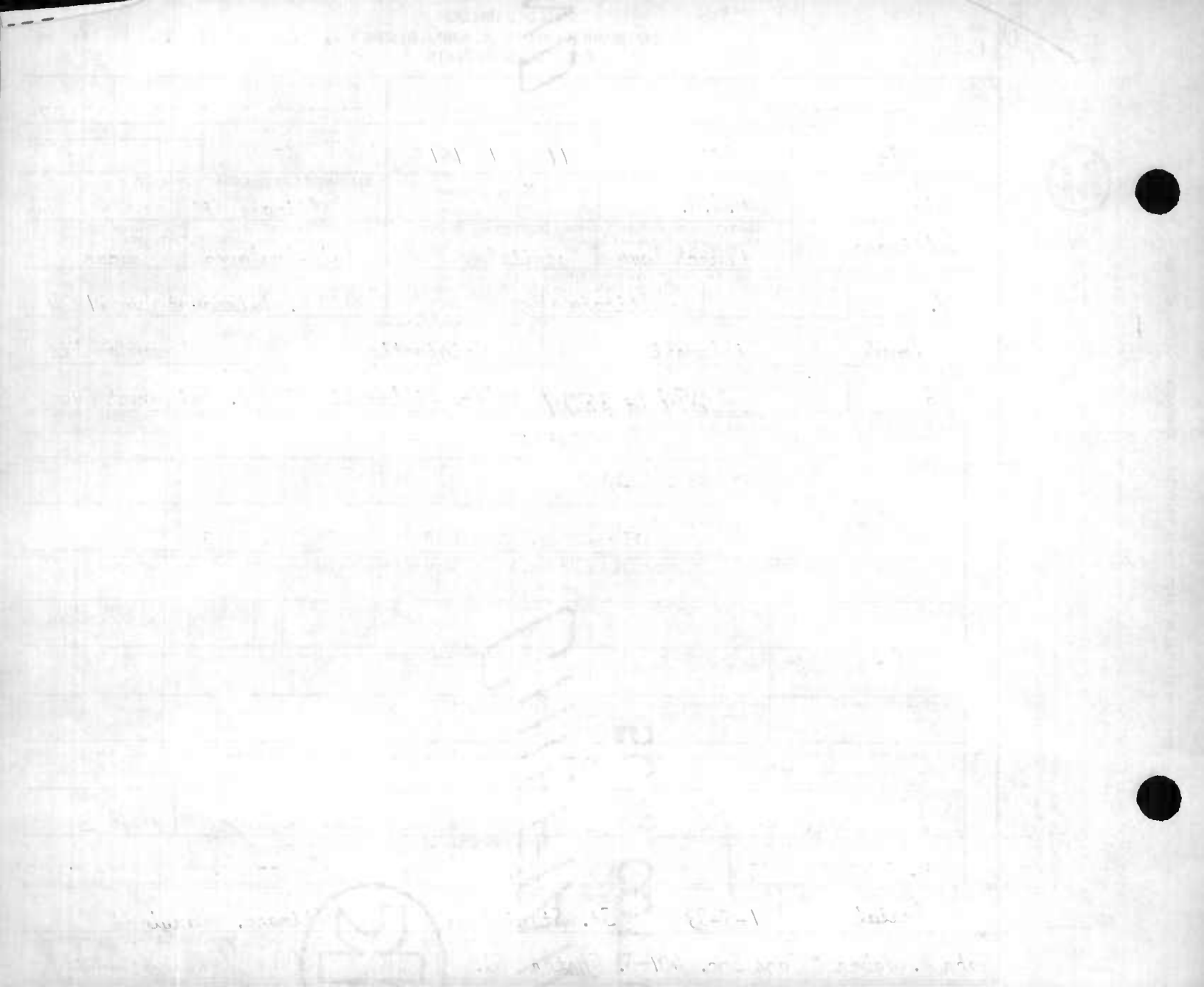
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8301194

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ALBERT C. MILLER, SR.</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1-28-83</b> |   |  | 2b. HOUR<br>M  |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2-16-1930</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>52</b> YRS.                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY - MD.</b>                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MERCY HOSPITAL</b>  |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>FIREFIGHTER</b> |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CITY</b>  |  | 13a. STREET ADDRESS<br><b>21234 8719 WENDELL AVE.</b>   |  | 13b. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13c. CITY OR TOWN<br><b>BALTO.</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN A. MILLER SR.</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MATILDA E. MEINSCHN</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>YES. KOREAN</b>                                      |  | 16b. SOCIAL SECURITY NO.<br><b>212-26-8057</b>   |  |
| 17. INFORMANT<br>ADDRESS<br><b>Mrs. Delores M. Miller - 21234 8719 WENDELL AVE.</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sepsis; Pusulent Endocarditis; Shock</b><br>4241<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CHF; A.T. Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>S/P Aortic Valve Regulator 2° to Aortic Stenosis</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |   |  |   |  |  |  |

## MEDICAL CERTIFICATION

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 21, 1983</b> to <b>JAN 28, 1983</b> , that (I) (we) last saw the deceased alive on <b>1/28/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Michael F. Platts MD</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/28/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MICHAEL F. PLATTS MD</b>   |  |  |  | 22e. ADDRESS<br><b>100 E. Pleasant St. Balto. 21202</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>2-1-83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MORELAND MEMORIAL</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John Miller - 7527 Stanford Rd.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 31 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 8301195  |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ANDREW H. MILLER</b>  |  |  |  | 2b. HOUR M<br><b>1-8-83</b>   |  |   |  |
| 3 SEX<br><b>M</b>  |  | 4 RACE<br><b>W</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>6-14-1913</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>69</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>131 N. PORT ST.</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>METAL SPRAYER</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BETH. STEEL</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 13a. STATE<br><b>MD.</b>   |  | 13b. COUNTY<br><b>BALTO.</b>   |  | 13c. CITY OR TOWN<br><b>BALTO.</b>  |  | 13e. STREET ADDRESS<br><b>131 N. PORT ST. 21224</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>ANDREW J. MILLER</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>KATHERINE HENNEMAN</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>217-05-6751</b>   |  | 17. INFORMANT ADDRESS<br><b>Mrs. Irene C. Miller - 131 N. Port St.</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4100</b> IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>HYPERTENSIVE HEART D.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>1964</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>MINUTES</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/30/82</b> , 19____, to <b>12/30/82</b> , 19____, that (I) (we) last saw the deceased alive on <b>12/30/82</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Max Baum</b>  |  |  |  | DEGREE<br><b>Attending Physician</b>  |  | 22c. DATE SIGNED<br><b>1/11/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MAX BAUM</b>   |  |  |  | 22e. ADDRESS<br><b>7422 Eastern Ave</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>1-12-83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OAK LAWN Cem.</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Heather Miller - 7527 Hanford Rd.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 11 1983</b>   |  |   |  |



Handwritten mark or signature at the bottom left corner.

Handwritten text at the bottom center, possibly a date or reference number.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 1 9 6

REG. NO.

|   |  |  |  |  |  |                                      |  |   |  |                     |  |        |  |      |  |          |  |      |  |
|---|--|--|--|--|--|--------------------------------------|--|---|--|---------------------|--|--------|--|------|--|----------|--|------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST                                 |  | 2a. DATE OF DEATH   |  | MONTH               |  | DAY    |  | YEAR |  | 2b. HOUR |  | MIN. |  |
| Levey   |  |  |  |  |  | Miller                               |  | 1   |  | 19                  |  | 1983   |  | 4:50 |  | P        |  | M    |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)      |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS.    |  | MONTHS |  | DAYS |  | HOURS    |  | MIN. |  |
| Male  |  | Black  |  | 10 09 05   |  | 77                                   |  | YRS.  |  |                     |  |        |  |      |  |          |  |      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |   |  |                     |  |        |  |      |  |          |  |      |  |
| N. Carolina   |  | U.S.A.   |  |  |  | Baltimore City                       |  |   |  |                     |  |        |  |      |  |          |  | MD   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY    |  |   |  |                     |  |        |  |      |  |          |  |      |  |
| Baltimore   |  | University Hospital  |  |  |  |                                      |  |   |  |                     |  |        |  |      |  |          |  |      |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  | 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN                    |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS |  |        |  |      |  |          |  |      |  |
| Maryland  |  |  |  |  |  | Baltimore                            |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1810 N. Fulton Ave  |  | 21217  |  |      |  |          |  |      |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |                                      |  |   |  |                     |  |        |  |      |  |          |  |      |  |
| Robert  |  | Miller   |  | Cove   |  | Best                                 |  |   |  |                     |  |        |  |      |  |          |  |      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                       |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT  |  | ADDRESS                              |  |   |  |                     |  |        |  |      |  |          |  |      |  |
| No  |  | 705-05-8375  |  | Dilha Miller   |  | 1810 N. Fulton Avenue                |  |   |  |                     |  |        |  |      |  |          |  |      |  |

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Respiratory Arrest

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

5 min.

DUE TO, OR AS A CONSEQUENCE OF

(b) Metastatic Prostatic cancer

1 year

DUE TO, OR AS A CONSEQUENCE OF

(c)

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Congestive heart failure, hypertension, Anemia

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/8 1983 to 1/19 1985, that (I) (we) lost saw the deceased alive on 1/19 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) did not view the body after death. |  | 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED   |  |
|  |  | Charles E. Sheehan M.D.  |  | MD   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |  |  |
| Charles E. Sheehan M.D.  |  | University of Maryland Hosp.   |  |  |  |  |  |

|   |  |                      |  |                                    |  |   |  |
|---|--|----------------------|--|------------------------------------|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) |  | 23b. DATE            |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION CITY OR TOWN COUNTY STATE |  |
| BURIAL                                    |  | 1/24/83              |  | Arbutus Mem. Pk.                   |  | Arbutus Md.                             |  |
| 24. FUNERAL DIRECTOR NAME                 |  | 24b. ADDRESS         |  | 25a. DATE RECEIVED BY REGISTRAR    |  | 25b. REGISTRAR'S SIGNATURE              |  |
| Wm. C. March F/H Inc.                     |  | 1101 E. North Avenue |  | JAN 21 1983                        |  | John J. Smith                           |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene. Page 4 should be filed with the funeral home.

IMPORTANT: If item 21 is marked or item 16 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |
|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 83 01197  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 2a. DATE OF DEATH   |  |
| SYLVESTER MILLER  |  | JANUARY 16, 1983  |  |
| 3. SEX  |  | 2b. HOUR  |  |
| MALE  |  | 2:06P M   |  |
| 4. RACE   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| WHITE   |  | 72 YRS.   |  |
| 5. DATE OF BIRTH  |  | IF UNDER 1 YEAR   |  |
| 12 15 1910  |  | MONTHS DAYS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | IF UNDER 24 HRS   |  |
| MARYLAND  |  | HOURS MIN   |  |
| 7b. CITIZEN OF WHAT COUNTRY?  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| U.S.A.  |  | BALTIMORE CITY MD   |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)       |  |
| 10. CITY OR TOWN OF DEATH   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| BALTIMORE   |  | RETIRED   |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  | 13a. STREET ADDRESS   |  |
| THE JOHNS HOPKINS HOSPITAL  |  | 203 S. MADEIRA ST.  |  |
| 13a. STATE  |  | 13b. CITY OR TOWN   |  |
| MARYLAND  |  | BALTIMORE   |  |
| 13c. COUNTY   |  | 13d. INSIDE CITY LIMITS?  |  |
| BALTIMORE   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME (TYPE OR PRINT)   |  | 15. MOTHER'S MAIDEN NAME (TYPE OR PRINT)                            |  |
| MICHAEL   |  | MARY MICHALAK   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  | 16b. SOCIAL SECURITY NO.  |  |
| NO  |  | 216036528   |  |
| 17. INFORMANT   |  | ADDRESS   |  |
| FUNICE MILLER   |  | 203 S. MADEIRA ST.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |
| PART I. DEATH WAS CAUSED BY:  |  |   |  |
| 1539 IMMEDIATE CAUSE (a) Cardio-pulmonary arrest  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |
| (b) Metastatic colon carcinoma  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |
| (c)   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |
| NA  |  | NA  |  |
| 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY   |  |
|   |  | HOUR A.M. MONTH DAY YEAR  |  |
|   |  | P.M. NA 19  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. LOCATION   |  |
| NA  |  | STREET CITY OR TOWN COUNTY STATE                                    |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION   |  |
| NA  |  | STREET CITY OR TOWN COUNTY STATE                                    |  |
| 21g. LOCATION   |  | 21h. LOCATION   |  |
| STREET CITY OR TOWN COUNTY STATE  |  | STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-16-83, to 1-16-83, that (II) (we) last saw the deceased alive on 1-16-83, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.) |  | 22c. DATE SIGNED  |  |
| 22b. SIGNATURE  |  | 1-16-83   |  |
| Joseph S. Weinstein   |  | 22d. ADDRESS  |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22f. ADDRESS  |  |
| Joseph S. Weinstein   |  | Johns Hopkins Hospital  |  |
| 23. BURIAL, CREMATION, REMOVAL  |  | 23b. DATE   |  |
| BURIAL  |  | 1/19/83   |  |
| 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |  |
| ST. STANISLAUS  |  | BALTIMORE MD  |  |
| 23e. DATE REC'D. BY REGISTRAR   |  | 23f. REGISTRAR'S SIGNATURE  |  |
| 1/19/83   |  | Jan. 2. 1983  |  |

1 JUL 20 1951  
U. S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

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FILE

13-00000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1. DECEASED NAME   |         | 2a. DATE OF DEATH   |        | 2b. HOUR  |   |
|--|---------|---|--------|---|---|
| FIRST  | MIDDLE  | MONTH   | DAY    | YEAR  |   |
| PRESTON J. MILLS   |         | 1   | 26     | 83  | 2:15am  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  |        | 6. AGE (IN YEARS LAST BIRTHDAY)   |   |
| MALE   | Black   | MONTH   | DAY    | YEAR  | 69 YRS.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?  |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| New Jersey   |         | USA   |        | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY, MD.   |   |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |   |
| BALTIMORE  |         | VAMC, BALTIMORE, MARYLAND 21218   |        | Construction  |   |
| 13a. STATE   |         | 13b. COUNTY   |        | 13c. CITY OR TOWN   |   |
| Maryland   |         |   |        | Baltimore   |   |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME  |        | 13d. STREET ADDRESS   |   |
| FIRST  | MIDDLE  | LAST  | FIRST  | MIDDLE  | LAST  |
| Orlando  |         | Mills   | Hester |   | Baker   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |         | 16b. SOCIAL SECURITY NO.  |        | 17. INFORMANT   |   |
| Yes  |         | WW II   |        | Upper Marlboro, Md.<br>Franklin Mills/11303 Sherrington Crt.  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:   |         |   |        |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| 0389 IMMEDIATE CAUSE (a) <u>Pneumonia</u>  |         |   |        |   |   |
| DUE TO, OR AS A CONSEQUENCE OF   |         |   |        |   |   |
| (b) <u>Septic sp (L) AKA</u>   |         |   |        |   |   |
| DUE TO, OR AS A CONSEQUENCE OF   |         |   |        |   |   |
| (c) <u>LS AKA 2° gangrene</u>  |         |   |        |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.  |         |   |        |   |   |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        | 20a. AUTOPSY?   |   |
| 12-26-82   |         | Wet Gangrene  |        | YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>DECEMBER 27</u> , 19 <u>82</u> , to <u>JANUARY 26</u> , 19 <u>83</u> , that (I) (we) lost<br>saw the deceased alive on <u>JANUARY 26</u> , 19 <u>83</u> , and that in <u>(X)</u> (our) opinion death occurred on the date and hour and from the causes stated<br>above, <u>(X)</u> (we) (did) (did not) view the body after death. |         |   |        |   |   |
| 22b. SIGNATURE   |         | DEGREE  |        | 22c. DATE SIGNED  |   |
| <u>Alexander Jones</u>   |         | M.D.  |        | 1/27/83   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |         | 22e. ADDRESS  |        |   |   |
| <u>Alexander Jones M.D.</u>  |         | VAMC, Baltimore, Maryland 21218   |        |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |         | 23b. DATE   |        | 23c. NAME OF CEMETERY OR CREMATORY  |   |
| Burial   |         | 1-29-83   |        | Gate of Heaven Cem  |   |
| 24. FUNERAL DIRECTOR   |         | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |        | 23e. DATE REC'D. BY REGISTRAR   |   |
| MARSHALL'S FUNERAL HOME  |         | 2417 9th St. NW<br>Washington, D.C.   |        | FEB 1 1983  |   |
| 25a. DATE REC'D. BY REGISTRAR  |         | 25b. REGISTRAR'S SIGNATURE  |        |   |   |
| FEB 1 1983   |         | <u>John E. Conner</u>   |        |   |   |

BP-562



208 COTTON  
T/E/M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 01199

REG. NO.

|  |  |  |  |   |  |   |   |  |  |
|--|--|--|--|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Libby B. Mintzes</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01 11 83</b>                 |   |  | 2b. HOUR<br><b>954</b> M  |   |  |  |
| 3 SEX<br><b>FEMALE</b>   |  | 4 RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>02 06 08</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SECRETARY</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BUSINESS</b>   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTO.</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 13e. STREET ADDRESS<br><b>7207 VALLEY COUNTRY CT., APT. T-3 #21208</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>FRANK BLAUSTEIN</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>TILLIE KLING</b> |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216-03-8253</b>  |  | 17. INFORMANT<br><b>MRS. FRANCES TENZ</b>   |  | APT. 207<br><b>BALTO., MD 21209</b>   |   |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiogenic &amp; hypovolemic Shock</b><br><b>5700</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Gastrointestinal Hemorrhage</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Massive hepatic Necrosis</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Diabetes Mellitus, Arteriosclerotic Heart Disease</b>  |  |  |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/10</b> 19 <b>83</b> to <b>1/11</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1/10</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Paul Schwartz</b>   |  |  | DEGREE<br><b>M.D.</b>  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1/11/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Paul Schwartz</b>  |  |  | 22e. ADDRESS<br><b>SINAI Hospital Baltimore 21215</b>                  |   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>JAN. 13, 1983</b>                                      |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BNAI ISRAEL</b>             |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 18 1983</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

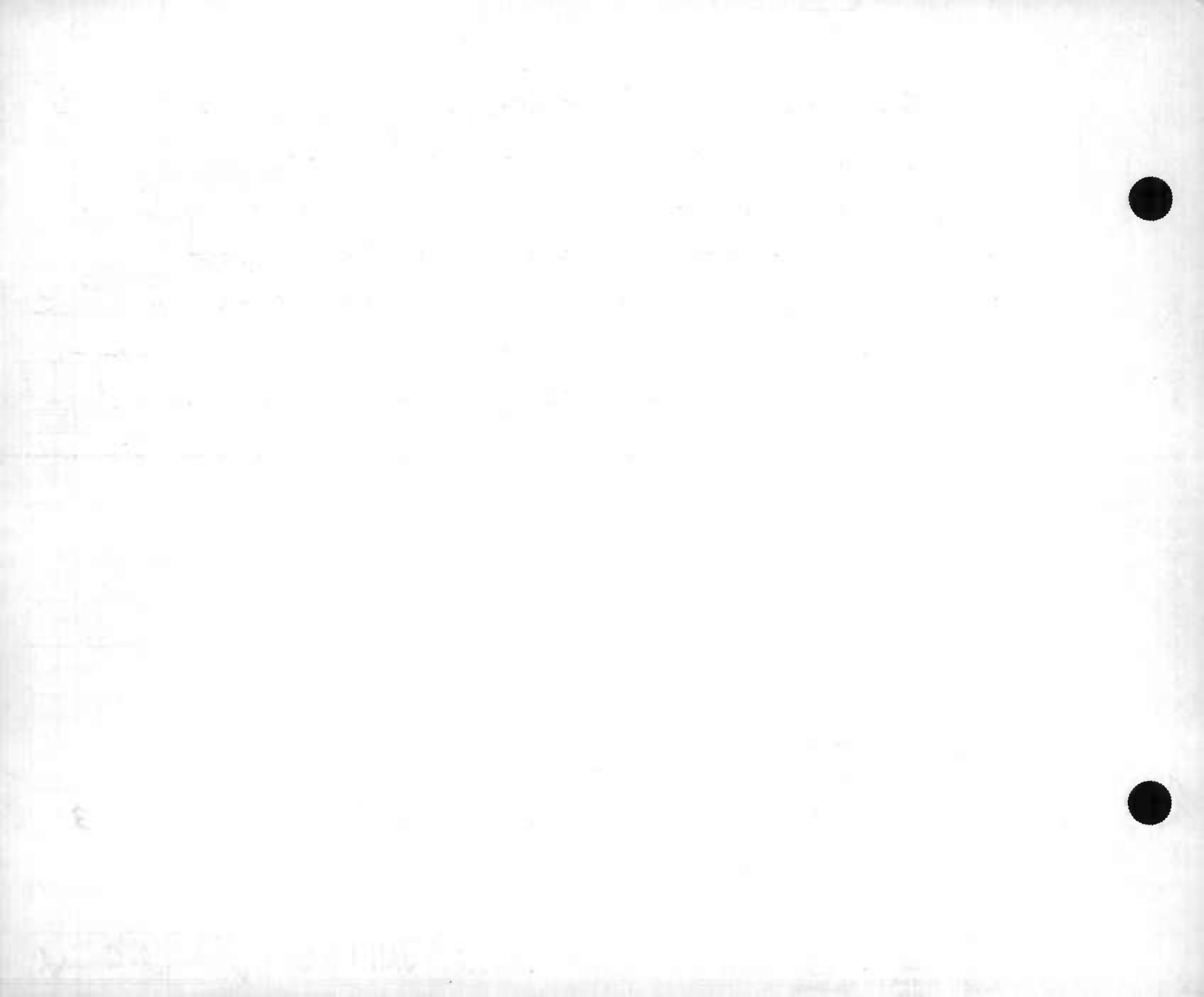
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 83 01200   |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Frances Elizabeth Mitchell</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 1 6 83  |  |   |  |
| 3. SEX <b>Female</b>  |  |  |  | 7b. HOUR 1 45 P M  |  |   |  |
| 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR 5 30 90  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 92   |  | 7a. MONTHS DAYS HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>Garrison</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Garrison Valley Center</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Stenographer</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Md</b> 13c. CITY OR TOWN <b>Baltimore</b>  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>1831 Kingston</b> 12229 12           |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Patrick Grady</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie Rooney Reamie</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  |  |  | 16b. SOCIAL SECURITY NO. <b>217-01-2882</b>  |  |   |  |
| 17. INFORMANT ADDRESS <b>Information gotten from Chart</b>  |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4280 IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b>  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 years</b>   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)  |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-27-1979 to 1-6-82, that (I) (we) last saw the deceased alive on 1-6-1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>Shaukat Y. Khan</b> M.D. DEGREE   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED <b>1-6-82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SHAUKAT Y. KHAN</b>  |  |  |  | 22e. ADDRESS <b>1528 KING WILLIAM DRIVE, BALTO, MD 21228</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>1-12-83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Riverview</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Charlottesville, Va.</b>   |  |
| 24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc., 5305 Harford Rd. Balto.</b> ADDRESS <b>Md.</b>  |  |  |  | 25a. DATE RECEIVED BY REGISTRAR <b>JAN 10 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>J. J. Connel</b>  |  |

BP \_\_\_\_\_





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY OCCURS, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |         |                  |   |                |                  |  |  |  |   |  |  |                                      |  |  |
|--|---------|------------------|---|----------------|------------------|--|--|--|---|--|--|--------------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         |                  | FIRST MIDDLE LAST   |                |                  | 2a. DATE KNOWN OF DEATH  |  |  | MONTH DAY YEAR  |  |  | 2b. HOUR                             |  |  |
| James J. Mitchell  |         |                  |   |                |                  | 15 1983  |  |  |   |  |  | 12:10                                |  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS)   | IF UNDER 1 YR. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD   |  |  | MONTH DAY YEAR  |  |  | 2d. HOUR                             |  |  |
| male   | Black   | 10 21 41         | 41 YRS.   |                |                  | 15 1983  |  |  |   |  |  | a M                                  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         |                  | 7b. CITIZEN OF WHAT COUNTRY?  |                |                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  | MD.                                  |  |  |
| Virginia   |         |                  | U.S.A.  |                |                  |  |  |  | Baltimore City,   |  |  |                                      |  |  |
| 10. CITY OR TOWN OF DEATH  |         |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |                                      |  |  |
| Baltimore  |         |                  | 1730 Montpelier   |                |                  |  |  |  |   |  |  |                                      |  |  |
| 13a. STATE   |         |                  | 13b. COUNTY   |                |                  | 13c. CITY OR TOWN  |  |  | 13d. INSIDE CITY LIMITS?  |  |  | 13e. STREET ADDRESS                  |  |  |
| Maryland   |         |                  |   |                |                  | Baltimore  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 1730 Montpelier St. 21218            |  |  |
| 14. FATHER'S NAME  |         |                  | 15. MOTHER'S MAIDEN NAME  |                |                  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT ADDRESS                |  |  |
| FIRST MIDDLE LAST  |         |                  | FIRST MIDDLE LAST   |                |                  | No   |  |  | 214-38-6379   |  |  | Lorraine D. Mitchell 1730 Montpelier |  |  |
| Jessie Mitchell  |         |                  | Callie Greenwood  |                |                  |  |  |  |   |  |  |                                      |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Stab wound of leg</u><br>9660<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |         |                  |   |                |                  |  |  |  |   |  |  |                                      |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |         |                  |   |                |                  |  |  |  |   |  |  |                                      |  |  |
| 19a. DATE OF OPERATION   |         |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                |                  | 20. AUTOPSY?   |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |                                      |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |                  | 21b. TIME OF INJURY   |                |                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |   |  |  |                                      |  |  |
| 11:50 P.M.   |         |                  | 1 14 1983   |                |                  | Subject stabbed  |  |  |   |  |  |                                      |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |         |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |                |                  | 21f. LOCATION  |  |  | COUNTY  |  |  | STATE                                |  |  |
| home   |         |                  | 1730 Monpelier  |                |                  | Baltimore  |  |  |   |  |  | Md.                                  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                  |   |                |                  |  |  |  |   |  |  |                                      |  |  |
| ACTUAL SIGNATURE   |         |                  | TITLE (SPECIFY)   |                |                  | DATE SIGNED  |  |  |   |  |  |                                      |  |  |
| Thomas D. Smith, M.D.  |         |                  | Deputy Chief  |                |                  | 1/15/83  |  |  |   |  |  |                                      |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |                  | ADDRESS   |                |                  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE   |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |
| Thomas D. Smith, M.D.  |         |                  | 111 Penn St. Balto., MD.  |                |                  | BURIAL   |  |  | 1/20/83   |  |  | Arbutus Mem. Pk.                     |  |  |
| 24. FUNERAL DIRECTOR NAME  |         |                  | 25a. DATE REC'D. BY REGISTRAR   |                |                  | 25b. REGISTRAR'S SIGNATURE   |  |  |   |  |  |                                      |  |  |
| Wm.C.March F/H Inc. 1101 E. North Ave-   |         |                  | JAN 17 1983   |                |                  | John J. Carver   |  |  |   |  |  |                                      |  |  |
| 23d. LOCATION  |         |                  | COUNTY  |                |                  | STATE  |  |  |   |  |  |                                      |  |  |
| Arbutus  |         |                  |   |                |                  | Md.  |  |  |   |  |  |                                      |  |  |

UNITED STATES GOVERNMENT  
DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT



RECEIVED  
JUL 10 1964  
BUREAU OF LAND MANAGEMENT  
U.S. DEPARTMENT OF THE INTERIOR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 3 0 1 2 0 2  |  |   |  |
|--|--|--|--|--|--|---|--|
| FOR STATE REGISTRAR <u>Louise</u>  |  |  |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <u>Louise</u> <u>Mitchell</u>   |  |  |  | 2a. DATE OF DEATH MONTH <u>01</u> DAY <u>11</u> YEAR <u>83</u>   |  | 2b. HOUR <u>6<sup>03</sup></u> M  |  |
| 3. SEX <u>F</u>  | 4. RACE <u>B</u>                       | 5. DATE OF BIRTH MONTH <u>04</u> DAY <u>05</u> YEAR <u>06</u>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <u>76</u> YRS.   |  | 7. IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u> IF UNDER 24 HRS. HOURS <u></u> MIN. <u></u>                              |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MD</u>   | 9. CITIZEN OF WHAT COUNTRY? <u>USA</u> |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD. |   |  |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Univ. of Md.</u> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Homemaker</u>                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MD</u>  |  | 13b. COUNTY <u>Baltimore</u>   |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                   |  | 13d. STREET ADDRESS <u>1118 W. Lafayette Ave</u>  |  |
| 14. FATHER'S NAME FIRST <u>John</u> MIDDLE <u>M. RONELL</u> LAST <u></u>   |  | 15. MOTHER'S MAIDEN NAME FIRST <u>Sallie</u> MIDDLE <u>Parker</u> LAST <u></u>   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u> (IF YES, GIVE WAR OR DATES) <u></u> |  |   |  |
| 16b. SOCIAL SECURITY NO. <u>217-05-9006</u>  |  | 17. INFORMANT <u>4611 DRES 5114 3118</u>   |  | 17. INFORMANT <u>BEATRICE M. JACOBSON</u>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u>   |  |  |  |  |  | <u>mm.</u>  |  |
| 5860 DUE TO, OR AS A CONSEQUENCE OF (b) <u>renal failure</u>   |  |  |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>severe malnutrition</u>  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                              |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                 |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/11/83</u> to <u>1/11/83</u> that (I) (we) lost saw the deceased alive on <u>1/11/83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE <u>Kathy M. Robie Suh</u> DEGREE  |  |  |  | 22c. DATE SIGNED <u>1/11/83</u>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>K. Robie-Suh</u>  |  |  |  | 22e. ADDRESS <u>Univ. of Md. Hosp.</u>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>  |  | 23b. DATE <u>1/14/83</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>MD Avenue</u>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore MD</u>   |  |
| 24. FUNERAL DIRECTOR <u>MD 44755 638 N Gilman St</u>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <u>JAN 17 1983</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>  |  |

BP



Handwritten text, mostly illegible due to blurriness. Some words like "Bureau" and "Office" are faintly visible.

Large block of handwritten text in the center of the page, mostly illegible.

Handwritten text at the bottom of the page, including what appears to be a signature and some dates or numbers.

RELEASED NON-MED DR. KORELL PER MR. PURVIS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

RELEASED NON-MED DR. KORELL PER MR. PURVIS  
MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   | 8 3 0 1 2 0 3   |  |   |  |  |
|---|--|--|--|---|---|--|---|--|--|
| 1 - STATE REGISTRAR   |  |  |  |   | REG. NO.  |  |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ELMER MITTWOCH</b>   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>JANUARY 11, 1983</b>               |  |   |  | 2b. HOUR<br><b>9:52 P</b>  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>August 3, 1922</b>  |   | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>60</b>   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 74 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wisconsin</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                              |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired Lt. Colonel</b> |   | 12b. INDUSTRY OF BUSINESS OR INDUSTRY<br><b>Air Force</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Florida</b>  |  |  |  |   | 13b. COUNTY <b>St. Walton Beach</b>                                       |  | 13c. STREET ADDRESS<br><b>610 N. Overbrook Drive</b>                    |  | 99999  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Gottlieb Mittwoch</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br><b>Mina Schwartz</b>          |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br><b>WW 2 392-14-5648</b>                          |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Jacquelyn F. Mitwoch same as 13 c</b> |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4149 IMMEDIATE CAUSE (a) Ventricular Arrhythmias</b>  |  |  |  |   |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>2 hrs.</b> |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hypertension, Acidosis</b>   |  |  |  |   |   |  |   |  | <b>2 hrs.</b>  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |  |   |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>atherosclerotic cardiovascular disease, renal insufficiency</b>   |  |  |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION<br><b>1/11/83</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>coronary artery disease abdominal aortic aneurysm</b> |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                 |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                       |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/30/82</b> , to <b>1/11/83</b> , that (I) (we) lost saw the deceased alive on <b>1/11/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Stuart Bohrer</b>  |  |  |  |   |   | DEGREE<br><b>MD</b>  |   | 22c. DATE SIGNED<br><b>1/11/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>STUART BOHRER, M.D.</b>   |  |  |  |   |   | 22e. ADDRESS<br><b>Johns Hopkins 601 N. B'WAY BALTO. 21205 MD</b>                              |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Cremation</b>   |  |  | 23b. DATE<br><b>1-13-1983</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. Towson, Maryland</b>  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 13 1983</b>                       |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                     |  |  |



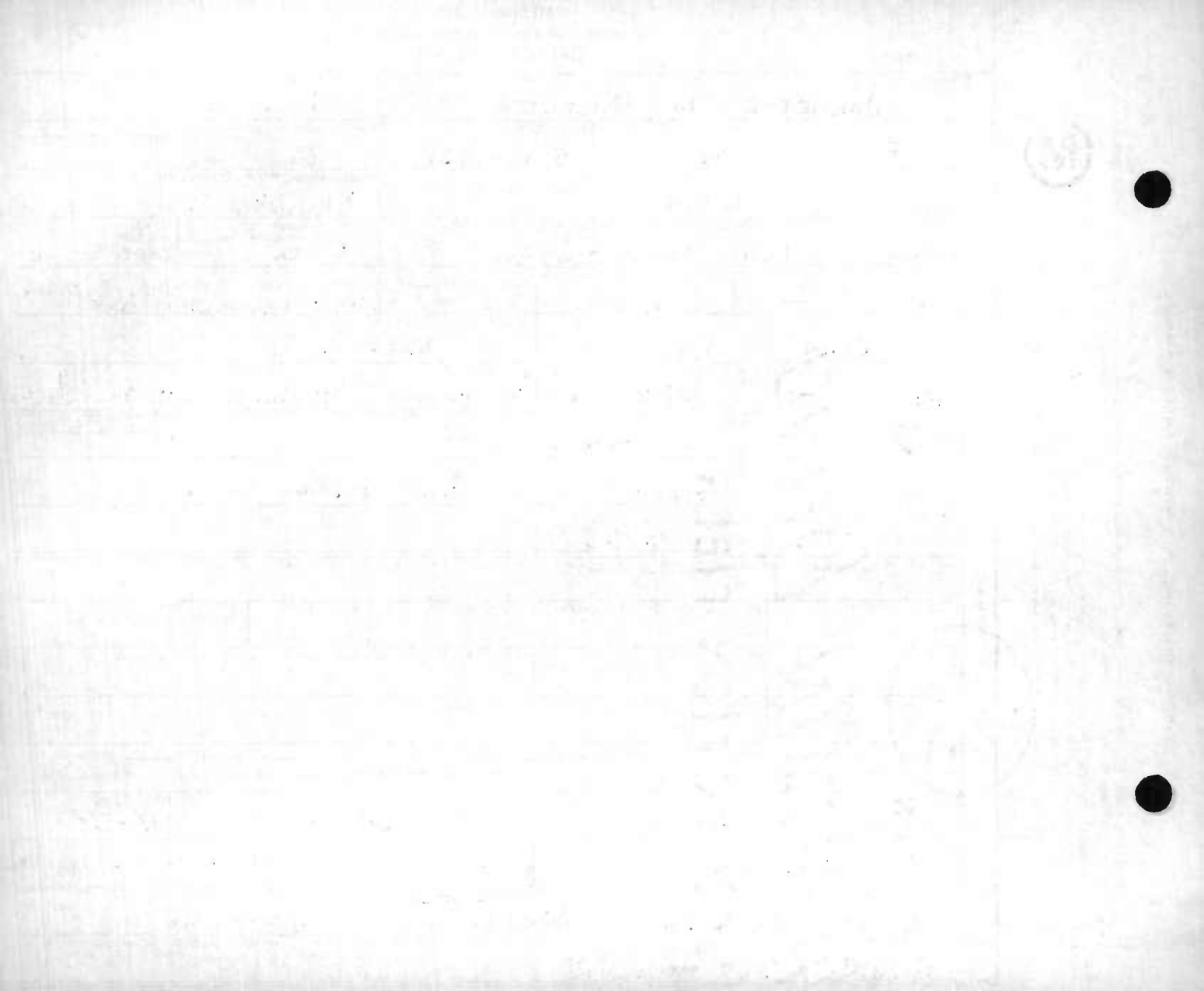


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 3 0 1 2 0 4   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>JANNETTE M. MOELTER  |  |   |  | 2a. DATE OF DEATH<br>1-22-83  |  | 2b. HOUR<br>M  |  |
| 3. SEX<br>F  |  | 4. RACE<br>W  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5-12-1921   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>61 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PENNSYLVANIA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>6411 LAURELTON AVE. |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CLERK  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>DEPT. STORE.  |  |
| 13a. STATE<br>MD.  |  |   |  | 13b. COUNTY<br>—  |  | 13c. CITY OR TOWN<br>BALTO.  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOHN HALL  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARY MOORE   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>212-16-2065   |  | 17. INFORMANT ADDRESS<br>Mr. Richard J. Moelter, Jr. - 6411 Laurelton Ave. 21214  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>2500 IMMEDIATE CAUSE (a) Cardiac arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Atherosclerotic Cardiovascular disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Diabetes<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Marshall A. Levine   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>1/25/83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Marshall A. Levine  |  |   |  | 22e. ADDRESS<br>711 W. 40th St., Baltimore, MD, 21201   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>1-26-82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GARDENS OF FAITH  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO., MD.  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>John W. Hill - 7527 Harford Rd.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 25 1983  |  |  |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>John W. Hill  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   | 8301205   |   |  |  |   |  |  |                 |  |  |
|--|--|--|--|---|---|---|--|--|---|--|--|-----------------|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   | REG. NO.  |   |  |  |   |  |  |                 |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BERGMAN F. MOESSINGER</b>   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01 29 83</b>                  |   |  |  |   | 2b. HOUR<br><b>7:40 A.M.</b>   |  |                 |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>Cauc.</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>02 07 16</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  |  | IF UNDER 24 HRS |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>35 Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |   |  |  |                 |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>50. Balto General Hosp</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Printer- Maran</b>       |  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Printing</b>   |  |                 |  |  |
| 13a. STATE<br><b>Md</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Dundalk</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>7006 Brentwood Avenue</b>  |   | 21222  |  |                 |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Wilhelm - Moessinger</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Minna - Bergman</b> |   |  |  |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>               |  |                 |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>216-03-8382</b>   |  |  |  |   | 17. INFORMANT<br><b>Jim McCadden</b>                                    |   |  |  |   | 28 W. Allegheny Avenue<br>Towson, MD. 21204  |  |                 |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ventricular arrhythmia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>myocardial infarction</b>   |  |  |  |   |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>20 min</b><br><b>12 hr</b>  |  |                 |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>g</b>  |  |  |  |   |   |   |  |  |   |  |  |                 |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                 |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |   |  |  |                 |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |                 |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>1-28</b> , 19 <b>83</b> , to <b>1-29</b> , 19 <b>83</b> , that (1) (we) lost<br>saw the deceased alive on <b>1-29</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (1) (we) did (did not) view the body after death. |  |  |  |   |   |   |  |  |   |  |  |                 |  |  |
| 22b. SIGNATURE<br><b>Anna Barnett</b>  |  |  |  | DEGREE<br><b>MD</b>   |   |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1-29-83</b>   |  |                 |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Anna Barnett</b>   |  |  |  | 22e. ADDRESS<br><b>3001 S. Hanover St. Balto Md</b>   |   |   |  |  |   |  |  |                 |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  |  | 23b. DATE<br><b>2/2/1983</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Mem. Pk.</b>                                  |  |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |                 |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222</b>   |  |  |  |   |   | 25a. DATE EFFECTIVE BY REGISTRATION<br><b>JAN 31 1983</b>                                       |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Davis</b>   |   |  |  |                 |  |  |

BP \_\_\_\_\_

8



20% COTTON

WILLIAMS



Jan 21 1903

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. GIVE PAGE 5 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS OF DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

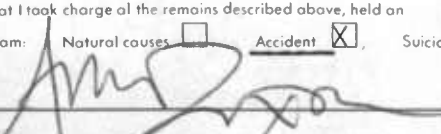

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |                         |                        |  |  |   |  |   |      |   |  |   |  |  |                          |  |  |   |  |  |  |  |  |
|--|--|-------------------------|------------------------|--|--|---|--|---|------|---|--|---|--|--|--------------------------|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LOUIS</b>  |  |                         | FIRST<br><b>MOLOCK</b> |  |  | MIDDLE<br><b>IV</b>   |  |   | LAST |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br><input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>1 22 19 83</b>         |  |  | 2b. HOUR<br><b>12:04</b> |  |  |   |  |  |  |  |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>Black</b> |                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 8 58</b>  |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br><b>24 YRS.</b>                      |  | IF UNDER 1 YR.<br>MONTHS DAYS   |      | IF UNDER 24 HRS.<br>HOURS MIN                                 |  | 2c. DATE PRONOUNCED DEAD<br><b>1 22 19 83</b>   |  |  | 2d. HOUR<br><b>12:04</b> |  |  |   |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  |                         |                        | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>   |  |  |                          |  |  |   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                         |                        | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |  |   |  |   |      | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY            |                          |  |  |   |  |  |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  |                         |                        | 13b. COUNTY  |  |   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |      |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                         |  |  |                          | 13e. STREET ADDRESS<br><b>1340 Cleveland St. 21230</b> |  |   |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Louis</b>   |  |                         |                        |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Barbara Johnson</b>     |  |   |      |   |  |   |  |  |                          |  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |  |                         |                        | (IF YES, GIVE WAR OR DATES)  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>218-74-0379</b>  |      |   |  | 17. INFORMANT ADDRESS<br><b>Barbara Molock 1340 Cleveland Street</b>  |  |  |                          |  |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cranio-cerebral trauma</b><br><b>8/20</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |  |                         |                        |  |  |   |  |   |      |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                          |  |  |   |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |                         |                        |  |  |   |  |   |      |   |  |   |  |  |                          |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                         |                        |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                           |  |   |      |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                     |  |  |                          |  |  |   |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |                        |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>8:25xx 1-13- 1983</b> |  |   |      |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br><b>Driver in auto/truck collision.</b> |  |  |                          |  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                         |                        |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>road</b>  |  |   |      |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Rts. 178 &amp; 32 Anne Arundel Md.</b>                          |  |  |                          |  |  |   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |                        |  |  |   |  |   |      |   |  |   |  |  |                          |  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE<br>  |  |                         |                        |  |  | TITLE (SPECIFY)<br>M.D. <b>Assistant</b> MEDICAL EXAMINER                   |  |   |      |   |  | DATE SIGNED <b>1-23-83</b>  |  |  |                          |  |  |   |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Ann M. Dixon, M.D.</b>   |  |                         |                        |  |  | ADDRESS<br><b>111 Penn St., Balto., Md. 21201</b>                           |  |   |      |   |  |   |  |  |                          |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |                         |                        |  |  | 23b. DATE<br><b>1/27/83</b>   |  |   |      |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Auburn Cem.</b>  |  |  |                          |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H Inc. 1101 E. North Avenue</b>  |  |                         |                        |  |  |   |  |   |      |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 24 1983</b>   |  |  |                          |  |  | 25b. REGISTRAR'S SIGNATURE<br> |  |  |  |  |  |



NOT RECORDED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8301207   |  |   |   |
|--|--|---|--|---|--|---|---|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   |  | REG. NO.  |  |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Carolyn R Moodispaw</i>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>Jan. 30 1983</i>   |  |   |   |
| 3. SEX<br><i>female.</i>   |  |   |  | 2b. HOUR<br><i>455P<sub>M</sub></i>   |  |   |   |
| 4. RACE<br><i>cauc.</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>04 18 33</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>49</i> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Va.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Balto. City</i> MD.  |   |
| 10. CITY OR TOWN OF DEATH<br><i>Balto.</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>South Balto. Gen. Hosp.</i> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>disabled.</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-----  |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |
| 13a. STATE<br><i>MD.</i>   |  | 13b. COUNTY<br><i>A.A. Co.</i>  |  | 13c. CITY OR TOWN<br><i>Gambrells</i>   |  | 13e. STREET ADDRESS<br><i>959 Central Lane</i> 21054  |   |
| 14. FATHER'S NAME<br>MIDDLE LAST<br><i>Eugene S PAW E. Moodispaw</i>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>MIDDLE LAST<br><i>Estelle Ames</i>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>220-74-134874</i>  |  | 17. INFORMANT<br>ADDRESS<br><i>Estelle Moodispaw 959 Central La. Gamb. Md.</i>  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><i>acute myocardial infarction</i><br>1919 IMMEDIATE CAUSE (a)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>hypertension</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |  |   |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/27</i> , 19 <i>83</i> , to <i>1/30</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>1/30</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |   |
| 22b. SIGNATURE<br><i>Alan Dennis</i>   |  |   |  | DEGREE  |  | 22c. DATE SIGNED<br><i>1/30/83</i>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Alan Dennis</i>  |  |   |  | 22e. ADDRESS<br><i>3001 S. Hanover St. Balto. MD.</i>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>2/2/83</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Baldwin Memorial</i>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Millersville, Md.</i>  |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Hardesty Funeral Home 12 Ridgely Ave. Ann. Md.</i>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>FEB 1 1983</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Smith</i>  |   |





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 1/81  
(VRA 15, 4)FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 2 0 8

REG. NO.

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>EDWARD B. MOORE</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-3-83</b>  |   | 2b. HOUR<br>M<br><b></b>   |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>B</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 03 05</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.                         | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b></b>  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.        |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secours Hospital</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)          | 12b. KIND OF BUSINESS OR INDUSTRY  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |   |   |  |
| 13a. STATE<br><b>Maryland</b>  | 13b. COUNTY<br><b></b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>1938 W. Franklin St. 21223</b>                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edward Moore</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Wilhemia</b>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>216-07-5962</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Mary E. Sellman 13 S. Pulaski Street</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio Pulmonary arrest</b><br><b>4149</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>hypertension</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Arterio Coronary</b> |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |
| 22a. I certify that (I) (this hospital), attended the deceased from <b>12/28</b> , 19 <b>82</b> , to <b>1/3</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1/3/83</b> , 19 <b></b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |
| 22b. SIGNATURE<br><b>Rolando M. Sabunwala, M.D.</b>  |  | DEGREE  |   | 22c. DATE SIGNED<br><b>1/3/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROLANDO M. SABUNWALA, M.D.</b>   |  | 22e. ADDRESS<br><b>Bon Secours Hospital</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(IF RECESS)<br><b>BURIAL</b>  | 23b. DATE<br><b>1/7/83</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. National Mem Pk</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Laurel MD.</b>           |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H Inc. 1101 E. north avenue</b>  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 6 1983</b>  |   |  |
|  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Lander</b>   |   |  |

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TO HOSPITAL-RETAIN ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 2 0 9

REG. NO.

|  |  |   |  |  |   |  |   |   |   |  |
|--|--|---|--|--|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FLORENCE P. MOORE   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 1, 1983                 |  |   | 2b. HOUR<br>M  |   |   |   |  |
| 3 SEX<br>Fe.   |  | 4 RACE<br>Black   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>9/18/1913   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS.  |   | 7 UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>City MD.  |   |   |   |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>344 Gwynn Ave. |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired Nurse  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Medicine   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.  |  |   | 13b. COUNTY<br>Balto.  |  | 13c. CITY OR TOWN<br>Balto.                                     |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>344 Gwynn Ave. 21229     |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Paris Anderson  |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Isabel Kyler           |  |   |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  |   | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>215 14 8222  |  | 17 INFORMANT<br>ADDRESS<br>Mrs. Isabel Moody 1812 Moreland Ave. |  |   |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>4100 IMMEDIATE CAUSE (a) <u>Sudden Death? due to</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Myocardial infarction.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>A.C.V.D.</u>                          |  |   |  |  |   |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |  |   |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |   |  |   |   |   |  |
| 22b. SIGNATURE<br>A. Shams, M.D.   |  |   |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A. Shams, M.D.  |  |   |  |  |   | 22e. ADDRESS<br>413 Commonwealth Ave. Balto.   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |   | 23b. DATE<br>1/5/83  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. National Mem          |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Laurel Md/  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>James A. Morton & Sons 1701 Laurens St.   |  |   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 4 1983  |   | 25b. REGISTRAR'S SIGNATURE<br>John J. Carver  |   |  |

W. C. V. D.  
Superior  
Golden State

W. C. V. D.  
Superior  
Golden State

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 3 0 1 2 1 0   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1 - FOR STATE REGISTRAR   |  |  |  | REG. NO.  |  |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>KIMBERLY ANN MOORE (BAILEY)</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 14 83</b>   |  | 2b. HOUR<br><b>5<sup>23</sup> AM</b>  |   |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JAN 7 83</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>7 DAYS</b> YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |   |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>STAGNES HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |   |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>N</b>  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GARY BAILEY</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>DONNA LEE MOORE</b>   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br>ADDRESS<br><b>DONNA LEE MOORE 434 RANDOM RD</b>  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>7651</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Prematurity</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Mother's drug abuse</b>                              |  |  |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |   |
| 22b. SIGNATURE<br><b>Pedro P. Rodriguez</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22f. DATE SIGNED<br><b>1/15/83</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Pedro P. Rodriguez</b>  |  |  |  | 22e. ADDRESS<br><b>WILKINS AVE.</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>1-17-83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WESTVIEW MEM</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO MD</b>   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WEBER FUNERAL HOME</b>   |  | ADDRESS<br><b>EDMONDSON AVE</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 18 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>   |   |

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Final 81 NAL



## CERTIFICATE OF DEATH

REG. NO.

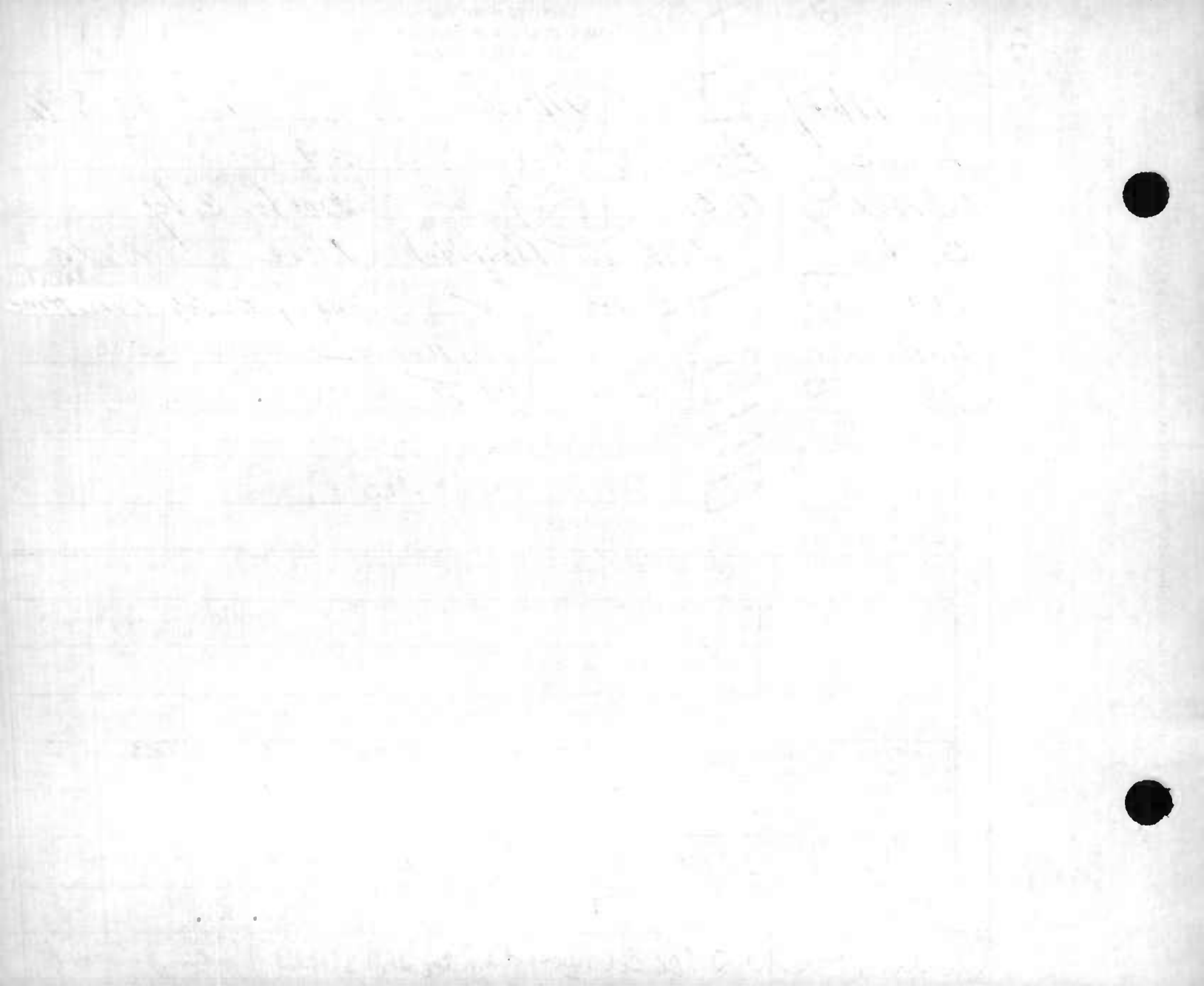
|   |  |   |   |   |   |   |   |   |  |
|---|--|---|---|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Mary</i> <i>Moore</i>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>1 7 83</i>                             |   |   | 2b. HOUR<br><i>8:34 AM</i>  |   |   |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>Black</i>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>1 4 13</i>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>69</i> YRS.                               |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Unknown</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Balto. City</i> MD.                  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Balto.</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Lutheran Hospital</i> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>None</i> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>None</i>  |  |
| 13a. STATE<br><i>MD</i>   |  |   | 13b. COUNTY<br><i>Balto.</i>  |   | 13c. CITY OR TOWN<br><i>Balto.</i>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Unknown</i>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Unknown Martha Fields</i> |   |   | 16. STREET ADDRESS<br><i>140 W. Lafayette Ave.</i>                              |   |   |  |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>no</i>   |  |   | 17b. SOCIAL SECURITY NO.<br><i>217-03-6374</i>                                |   | 17. INFORMANT<br>ADDRESS<br><i>Chesley L. Moore Husband</i>   |   |   |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardio Pulmonary arrest</i><br><i>4960</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>C.O.P.D. Diabetes</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) _____    |  |   |   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |   |   |   |   |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |   | 20b. IF WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                    |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1-3</i> , 19 <i>83</i> , to <i>1-7</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>1-7</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |   |   |   |   |  |
| 22b. SIGNATURE<br><i>G. Shah</i>  |  |   |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>DR. G. SHAH</i>   |  |   |   |   | 22e. ADDRESS<br><i>LUTHERAN HOSPITAL, BALTIMORE MD.</i>   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>   |  |   | 23b. DATE<br><i>1/11/83</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Cedar Hill</i>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Balto. Md.</i>                                 |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Edmondson</i>  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 10 1983</i>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Conner</i>   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be retained by the funeral director. Page 4 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 2 1 2

FOR  
1. STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>WILLIAM T. MOORE  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JANUARY 5 1983                           |  | 2b. HOUR<br>12:18 PM   |
| 3. SEX<br>Male   | 4. RACE<br>Cauc.   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 5 1910   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Hospital Corp. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Time Keeper |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Steel   |
| 13a. STATE<br>Md.  |  |   | 13b. COUNTY<br>-  | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William L. Moore   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Annie Sullivan                 |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII   |   | 17. INFORMANT<br>(Sister) 133 S. Robinson St.<br>Ann Crockett Baltimore, Md. 21224   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>1629 IMMEDIATE CAUSE (a) SMALL CELL UNDIFFERENTIATED CARCINOMA OF THE LUNGS WITH METASTASES TO THE LIVER<br>DUE TO, OR AS A CONSEQUENCE OF (b) LIVER<br>DUE TO, OR AS A CONSEQUENCE OF (c)                      |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 21g. I certify that (I) (this hospital) attended the deceased from 12/13/82, 19 to January 5, 1983, that (I) (we) lost<br>saw the deceased alive on Jan 5, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |
| 22b. SIGNATURE<br>Melito Torres  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br>1/5/83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MELITO TORRES, M.D.   |  | 22e. ADDRESS<br>CHURCH HOSPITAL CORPORATION<br>100 N. BROADWAY BALTIMORE, MD. 21231   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   | 23b. DATE<br>Jan. 8, 1983  | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn Cem.   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.                          |  |
| 24. FUNERAL DIRECTOR<br>NAME John A. Morany Inc.<br>2000 E. Baltimore St. Baltimore, MD 21224  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 7 - 1983   |   | 25b. REGISTRAR'S SIGNATURE<br>John J. Connel   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 48 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-338-1111.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 8 3 0 1 2 1 3  |  |  |  |  |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR                                     |  |
| BARTOW   |  | A.   |  |  |  | MORMAN   |  | 1-20-83   |  | 1:20 PM                                      |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. IF UNDER 1 YEAR MONTHS DAYS  |  | 8. IF UNDER 24 HRS. HOURS MIN.               |  |
| Male   |  | Black  |  | 2/8/1894   |  | 88   |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |  |  |
| Ga.  |  | U. S. A.   |  |  |  | City MD.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |  |   |  |  |  |
| Baltimore  |  | Lutheran Hospital Baltimore  |  |  |  |  |  |   |  |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |   |  |  |  |
| Retired Fed.   |  | Govt.  |  |  |  |  |  |   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13. STREET ADDRESS  |  |  |  |
| Md.  |  |  |  | Baltimore  |  |  |  | 1112 Myrtle Ave. 21201  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |   |  |  |  |
| Austin Morman  |  |  |  |  |  | HARRETTE   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT ADDRESS  |  |  |  |   |  |  |  |
| Yes  |  | W. W. I  |  | 214-38-9689  |  | Catherine T Law Waters 3527 Lynchester   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 4280 IMMEDIATE CAUSE (a) Congestive Heart Failure  |  |  |  |  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)   |  |  |  |  |  |  |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |  |  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |  |  |
|  |  | P.M. 19  |  |  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |  |  |
|  |  |  |  |  |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/30/82 to 1/20/83, that (I) (we) last saw the deceased alive on 1/20/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  |  |  | 22c. DATE SIGNED  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |  |  |   |  |  |  |
| MOGES GEBRE MARIAM   |  |  |  |  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |  |  |
| Burial   |  | 1/25/83  |  | Baltimore National   |  |  |  | Baltimore, Maryland   |  |  |  |
| 24. FUNERAL DIRECTOR NAME  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE  |  |   |  |  |  |
| Law Funeral Home 4611 Park Heights Ave   |  |  |  |  |  | FEB 7 1983 John J. Carver  |  |   |  |  |  |



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| FOR<br>1- STATE<br>REGISTRAR  |  |                         |  |   |  | B 301214<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH            |  |   |  |  |  | REG. NO.  |  |                                  |  |  |  |
|---|--|-------------------------|--|---|--|--|--|---|--|--|--|---|--|----------------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |                         |  |   |  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED                      |  |   |  |  |  | 2b. HOUR  |  |                                  |  |  |  |
| FIRST MIDDLE LAST<br><b>Esther PEARL Morris</b>   |  |                         |  |   |  | MONTH DAY YEAR<br><b>1 17 19 83</b>                            |  |   |  |  |  | M A M<br><b>10:32</b>   |  |                                  |  |  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>BLACK</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1-23-1926</b>  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS.<br><b>56</b>           |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   |  | IF UNDER 24 HRS.   |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>1 17 19 83</b>   |  | 2d. HOUR<br>M A M<br><b>a 32</b> |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD</b>   |  |                                  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3114 Leighton Avenue</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK)<br><b>TEACHER</b>  |  |  |  | 12b. KIND OF BUSINESS<br><b>BALT. PUBLIC SCH</b>  |  |                                  |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD.</b>  |  |                         |  | 13b. CITY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                          |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>3114 LEIGHTON AVE BALT. MD.</b>                    |  |   |  |                                  |  |  |  |
| 14. FATHER'S NAME<br><b>HOWARD M. DuVALL</b>  |  |                         |  |   |  | 15. MOTHER'S MAIDEN NAME<br><b>HELEN TRUXTON</b>               |  |   |  |  |  |   |  |                                  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE DATES)<br><b>NO NONE</b>   |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>220-20-3428</b>  |  | 17. INFORMANT<br><b>ERIC S. MORRIS</b>                         |  |   |  | ADDRESS<br><b>16092 LISBON ST. EAST LIVERPOOL OHIO</b>                       |  |   |  |                                  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4310 Spontaneous intra cerebral hemorrhage</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____                      |  |                         |  |   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>43920</b>  |  |                                  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |                         |  |   |  |  |  |   |  |  |  |   |  |                                  |  |  |  |
| 19a. DATE OF OPERATION  |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |  |                                  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |   |  |                                  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |                                  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                         |  |   |  |  |  |   |  |  |  |   |  |                                  |  |  |  |
| ACTUAL SIGNATURE<br>  |  |                         |  | TITLE (SPECIFY)<br><b>M.D. Deputy Chief MEDICAL EXAMINER</b>  |  |  |  |   |  |  |  | DATE SIGNED<br><b>1/17/83</b>   |  |                                  |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Thomas D. Smith, M.D.</b>  |  |                         |  | ADDRESS<br><b>111 Penn St. Balto., MD.</b>  |  |  |  |   |  |  |  |   |  |                                  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |                         |  | 23b. DATE<br><b>1-21-83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MD. VETERANS CEM.</b> |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>CROWNSVILLE A.A.CO. MD.</b> |  |   |  |                                  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>NUTTER FUNERAL HOME 3035 W. NORTH AVE</b>  |  |                         |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 19 1983</b>   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br> |  |                                  |  |  |  |





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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

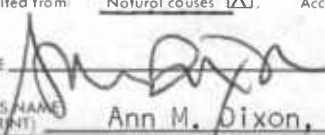

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |                           |  |  |  |  |  |  |  |
|--|--|---------------------------|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ROBERT E. MORRIS, Sr.</b>   |  |                           |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1 13 1983</b>  |  |  |  | 2b. HOUR <b>M</b>  |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>Black</b>      |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>8 19 17 65 YRS.</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b>  |  | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Va.</b>   |  |                           |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 7c. DATE PRONOUNCED DEAD <b>1 13 1983</b>  |  |                           |  | 9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>Baltimore City</b> MD.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |                           |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2847 Bookert Dr.</b>                              |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY  |  |                           |  |  |  |  |  |  |  |
| 13a. STATE <b>Md.</b>  |  | 13b. COUNTY <b>Balto.</b> |  | 13c. CITY OR TOWN <b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>2847 Bookert Dr. 21225</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Moses Morris</b>   |  |                           |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Annie Pannell</b>   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>  |  |                           |  | 16b. SOCIAL SECURITY NO. <b>224-14-6280</b>  |  | 17. INFORMANT ADDRESS <b>Robert Morris, Jr 2847 Bookert Dr.</b>                              |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                           |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |                           |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                           |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |                           |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> . and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                           |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE    |  |                           |  | TITLE (SPECIFY) <b>M.D. Assistant</b> MEDICAL EXAMINER   |  |  |  | DATE SIGNED <b>1-14-83</b>   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>  |  |                           |  | ADDRESS <b>111 Penn St., Balto., Md. 21201</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>1/18/83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Md. Vet. Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Crownsville, Md.</b>                           |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm C March F/H</b> ADDRESS <b>1101 E. North Ave.</b>   |  |                           |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 17 1983</b> REGISTRAR'S SIGNATURE  |  |  |  |  |  |



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM WP-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |         |  |  |   |  |   |  |                                |  |                                |  |   |  |
|--|---------|--|--|---|--|---|--|--------------------------------|--|--------------------------------|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN<br>OF DEATH     |  | XX MONTH DAY YEAR<br>1-31-83   |  | 2b. HOUR<br>19 M                                |  |
| CONSTANCE  |         | M.   |  | MORSELL   |  |   |  |                                |  |                                |  |   |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH<br>MONTH DAY YEAR   |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)  |  | IF UNDER 1 YR.<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN. |  | 2c. DATE<br>PRONOUNCED<br>DEAD |  | 2d. HOUR<br>7:18A M                             |  |
| female   | Black   | 8 2 40   |  | 42 YRS.   |  |   |  |                                |  | 1-31-83                        |  | 19 M  |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |                                |  |                                |  |   |  |
| Maryland   |         | U.S.A.   |  |   |  | Baltimore City  |  |                                |  |                                |  | MD  |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |  |                                |  |                                |  |   |  |
| Baltimore  |         | 804 Wilbert Avenue   |  |   |  |   |  |                                |  |                                |  |   |  |
| 13a. STATE   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS            |  |                                |  |   |  |
| Marland  |         |  |  | Baltimore   |  |   |  | 804 Wilbert Ave. 21212         |  |                                |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |  |   |  |   |  |                                |  |                                |  |   |  |
| Chester  |         | Goodie   |  | Lillian   |  | B. Blackwell  |  |                                |  |                                |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |                                |  |                                |  |   |  |
| Yes  |         | 218-36-4988  |  | Leroy J. Morsell  |  | 804 Wilbert Ave.  |  |                                |  |                                |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>4939 IMMEDIATE CAUSE (a) Asthma<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |         |  |  |   |  |   |  |                                |  |                                |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)   |         |  |  |   |  |   |  |                                |  |                                |  |   |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |                                |  |                                |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |                                |  |                                |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |         | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |                                |  |                                |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |         |  |  |   |  |   |  |                                |  |                                |  |   |  |
| ACTUAL<br>SIGNATURE  |         | TITLE (SPECIFY)<br>M.D. Assistant  |  | MEDICAL EXAMINER  |  | DATE<br>SIGNED  |  | 1-31-83                        |  |                                |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |         | ADDRESS  |  |   |  |   |  |                                |  |                                |  |   |  |
| Margarita A. Korell, M.D.  |         | 111 Penn Street  |  |   |  |   |  |                                |  |                                |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL  |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |                                |  |                                |  |   |  |
| BURIAL   |         | 2/5/83   |  | Baltimore Cem.  |  | Baltimore   |  |                                |  |                                |  | Md.   |  |
| 24. FUNERAL DIRECTOR<br>NAME   |         | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |                                |  |                                |  |   |  |
| Wm. C. March F/H Inc.  |         | 1101 E. North Ave.   |  | FEB 2 1983  |  | John J. Canfield  |  |                                |  |                                |  |   |  |



BRIDGE

WALK



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 2 1 7

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST<br>CONSTANCE M. -MULLANNEY-  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>JANUARY 3, 1983   |  | 2b. HOUR<br>2:30 a.m.   |   |
| 3. SEX<br>Female  |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>May 26, 1890   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>92 YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.   |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clerk   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Office   |   |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>-   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Unknown to Records  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Unknown to Records  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No N/A  |  |   |   |
| 16b. SOCIAL SECURITY NO.<br>216-07-0613   |  | 17. INFORMANT<br>99085 Carillon Dr.<br>John E. Dohler  |  | Ellicott City, 21043  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br>4149<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Severe Atherosclerotic Vessel Disease</b> years<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Coronary Artery Disease</b> years |  |  |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Alzheimer's disease</b>  |  |  |  |   |  |   |   |
| 19a. DATE OF OPERATION<br>December 20, 1982   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Chronic Decubiti   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that <input checked="" type="checkbox"/> this hospital attended the deceased from <b>November 22, 1982</b> to <b>January 3, 1983</b> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased above, <input checked="" type="checkbox"/> (we) did not view the body after death.                                 |  |  |  |   |  |   |   |
| 22b. SIGNATURE<br><i>John A. Lampe</i>  |  | DEGREE<br>MD   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br>1/3/83  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John A. Lampe, M.D.  |  | 22e. ADDRESS<br>c/o Maryland General Hospital  |  |   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>1/6/83  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cem.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore City, Maryland  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>MacNabb Funeral Home, Catonsville, MD   |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 4 1983   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Carroll</i>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP 15

1:30 p

JANUARY 1, 1953

HISTORICAL

IN HISTORY

Continued from

History of the Hospital

Continued from

Continued from

Continued from

Continued from

1953

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   |  |  |   |  |  |
|--|--|--|---|---|--|--|---|--|--|
| FOR<br>1 - STATE<br>REGISTRAR  |  |  |   |   | REG. NO. 01218   |  |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Baby Boy MULLINS</b>  |  |  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-24-83</b>  |  |   | 2b. HOUR<br><b>10 P M</b>  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1-24-83</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>57</b>                     |   | IF UNDER 1 YEAR<br>IF UNDER 24 HRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, City MD.</b>                   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>—</b>         |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD.</b> 13b. COUNTY <b>—</b> 13c. CITY OR TOWN <b>BALTIMORE</b>  |  |  |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>4113 HAGUE AVE 21225</b>  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert LEE Mullins</b>  |  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Carolyn SUE PHILLIPS</b>   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br><b>NONE</b>  |   | 17. INFORMANT ADDRESS   |  |  |   |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>7651</b> IMMEDIATE CAUSE (a) <b>cardiorespiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF,<br>(b) <b>immaturity of lungs</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>—</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |   |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>     |   |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Steven Miller</b>   |  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/24/83</b>                  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>STEVEN MILLER</b>  |  |  |   |   | 22e. ADDRESS   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/26/83</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Pk.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie, A. A. Md.</b>          |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Raymond C. Fink</b>   |  |  |   |   | ADDRESS<br><b>Glen Burnie, Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 27 1983</b> |  |  |
|  |  |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>  |  |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carboncopiers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

DHMH-16 50M1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 83 01219  |  |   |   |
|---|--|--|--|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Charles Murphy</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>1/07/83</b>   |  |   |   |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>4/08/17</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Midtown Home</b> |  | 12a. USUAL OCCUPATION<br>(NATURE OF WORK FOR MOST OF WORKING LIFE)<br><b>DISABLED</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Anne Arundel</b>   |  | 13c. CITY OR TOWN<br><b>Pasadena</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James E. Murphy</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Martha E. UNKNOWN</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Unknown</b>  |  |   |   |
| 16b. SOCIAL SECURITY NO.<br><b>214-03-6905C1</b>  |  | 17. INFORMANT<br><b>MIDTOWN N.H.</b>   |  |  |  | ADDRESS<br><b>808 ST. PAUL ST.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4100 ACUTE CORONARY THROMBOSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>GENERALIZED ARTERIOSCLEROSIS</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>Cerebral AS, CBS, RH Arthritis</b> |  |  |  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>8:21</b> P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)   |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>2435 W BELVEDERE</b> <b>PAUSD. CITY</b> <b>MD.</b>                                       |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8:21</b> 19 <b>74</b> , to <b>1:7</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1:7</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.  |  |  |  |  |  |   | 22c. DATE SIGNED                                |
| 22b. SIGNATURE<br><b>A. Enrique</b>   |  |  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A. ENRIQUE</b>  |  |  |  | 22e. ADDRESS<br><b>2435 W BELVEDERE 2145</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>1-12-83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>NEW CATH. CEM.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY<br><b>PAUSD. CITY</b> <b>MD.</b>   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>FARLEY F.H.</b>  |  |  |  | 25a. DATE REC'D BY REGISTRAR<br><b>JAN 11 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. J. Connel</b>   |   |

MEDICAL CERTIFICATION



12:42A 1A07/83 Anthony Charles

62 01/08/17 W W

Baltimore City U.S.A.

Midtown Home Baltimore

30 Solly Rd. Anne Arundel Kennelwood Md.

E. Murphy James

414-03-00000 Unknown

JAN 11 1983

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | REG. NO. 01221                                       |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Thomas Elbert Murray</b>  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> |  | MONTH DAY YEAR <b>1 13 19 83</b>   |  | 7b. HOUR <b>8:15</b>                                 |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>NEGRO</b>                       |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>MAY 6 - 24 58 YRS.</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.  |  | 7c. DATE PRONOUNCED DEAD <b>1 13 19 83</b>           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>                                     |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2707 E. Preston St.</b>                       |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>                 |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Produce Co.</b> |  |
| 13a. STATE <b>MD.</b>  |  |  |  | 13b. COUNTY <b>Baltimore</b>   |  | 13c. CITY OR TOWN <b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>2707 E. Preston St. 21213</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>TOM MURRAY</b>   |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>ELISHAWN MURRAY</b>                           |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>   |  |  |  | 16b. SOCIAL SECURITY NO. <b>244-20-1548</b>  |  | 17. INFORMANT ADDRESS <b>Mrs. Emma Murray 2707 E. Preston</b>                                  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: <b>4292</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH         |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>10</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Hormez R. Guard</b>  |  |  |  | M.D. <b>Assistant</b>  |  |  |  | DATE SIGNED <b>1/13/83</b>   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>   |  |  |  | ADDRESS <b>111 Penn St., Balto., Md.</b>   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>1-17-83</b>                   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore City</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>                                |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Randolph J. Collick</b> ADDRESS <b>2431 E. Oliver St.</b>  |  |  |  |  |  | 25. DATE REC'D. BY REGISTRAR <b>JAN 18 1983</b> REGISTRAR'S SIGNATURE <b>John J. Connel</b>    |  |  |  |  |  |

MEDICAL CERTIFICATION



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be made.

| FOR<br>1. STATE<br>REGISTRAR   |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 3 0 1 2 2 0<br>REG. NO.  |  |  |  |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Marv (Mamie) L. Murphy</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1/9/83</b>  |  |   |  | 2b. HOUR<br>MIN.<br><b>7:15 P</b>  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 6, 1889</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>96</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore, Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                                    |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Jenkins Memorial Home<br/>1000 S. Caton Ave. Balt; Md.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>School Teacher-Balto. City</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>---</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |  | 13e. STREET ADDRESS<br><b>21224<br/>2528 E. Baltimore Street</b>                     |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James F. Murphy</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>? ? Callanin</b>  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>220-20-1959</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Elizabeth Braun-8027 Highpoint<br/>Balto., Md. 21234- Rd.</b>     |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b><br><b>4029</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>HYPERTENSIVE ARTERIO SCLEROTIC CV Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>10 YRS.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 Hour</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                        |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>NOV. 20, 1979</b> to <b>JAN 9, 1983</b> , that (we) lost saw the deceased alive on <b>JAN 9, 1983</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>John F. Hartman</b><br>DEGREE<br><b>M.D.</b>  |  |  |  |   |  |   |  | 22c. DATE SIGNED<br><b>JAN. 10, 1983</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN F. HARTMAN</b>  |  |  |  |   |  |   |  | 22e. ADDRESS<br><b>JENKINS MEMORIAL HOME<br/>1000 S. CATON AVE. 21229</b>            |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  |  | 23b. DATE<br><b>Jan. 12, 1983</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cemetery-Baltimore, Md.</b>                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John A. Moran, Inc.<br/>Funeral Home-3000 E. Baltimore, Md. 21224.</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 11 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Smith</b>                                   |  |  |  |

BP





Jan. 6, 1957

White

White

Self phone

Business

Ad.

Local

No

RECEIVED JAN 10 1957

NO

Mr. F. H. [illegible]

Mr. F. H. [illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   | REG. NO.  |   |
|--|--|--|---|---|---|---|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>BRENDA JOHNSON Muse</b>  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>1/1/83</b>             |   | 2b HOUR<br><b>11:20 AM</b>  |   |
| 3 SEX<br><b>F</b>  | 4 RACE<br><b>N</b>   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 3 56</b>   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>26</b> YRS                 |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S. Carolina</b>   | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD.          |   |   |   |
| 10 CITY OR TOWN OF DEATH<br><b>BALT</b>  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b KIND OF BUSINESS OR INDUSTRY  |   |
| 13a STATE<br><b>MD</b>   |  | 13b COUNTY<br><b>CITY</b>  | 13c CITY OR TOWN<br><b>BALT</b>                                 | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                  | 13e STREET ADDRESS<br><b>3509 Hayward</b>   |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John C. Johnson</b>  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Viola JOHNSON</b>   |   |   |   |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b SOCIAL SECURITY NO.<br><b>216-58-3272</b>  |   | 17 INFORMANT ADDRESS<br><b>Viola Johnson 3509 Haywood Avenue</b>  |   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Respiratory arrest</b><br><b>5739</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Liver De</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>9</b>   |  |  |   |   |   |   |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC.)   |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.   |  |  |   |   |   |   |
| 22b SIGNATURE<br><b>C. Controressi, MD</b>   |  | DEGREE<br><b>MD</b>  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c DATE SIGNED<br><b>1/2/83</b>                                      |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CSCONTRORESSI</b>   |  | 22e ADDRESS<br><b>SINAI Hoop</b>   |   |   |   |   |
| 23a BURIAL, CREMATION, REMOVAL<br>(SP) <b>BURIAL</b>   |  | 23b DATE<br><b>1/6/83</b>  |   | 23c NAME OF CEMETERY OR CREMATORY<br><b>Mount Calvary Cem.</b>  |   | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. Md.</b> |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H Inc. 1101 E. North Avenue</b>   |  |  |   | 25a DATE REC'D. BY REGISTRAR<br><b>JAN 4 1983</b>   |   | 25b REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                    |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |  |
|---|--|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   | REG. NO. 8301223   |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>CHARLES Julian NAGLE</b>  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>01 19 83</b>                       |  |  |   |  |
| 2b. HOUR <b>5:50 PM</b>   |  |   |  |   |  |  |  |   |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 24 1900</b>   |  | 6. AGE (IN YEARS (LAST BIRTHDAY)) <b>82</b>  |  | 7. IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  | 9. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.                              |  |   |  |
| 12. CITY OR TOWN OF DEATH <b>BALTIMORE</b>  |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b> |  |   |  | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>U.S. Navy</b>                |  | 15. KIND OF BUSINESS OR INDUSTRY <b>-</b>   |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |  |  |   |  |
| 17a. STATE <b>Md.</b>   |  | 17b. COUNTY <b>-</b>  |  | 17c. CITY OR TOWN <b>Balto.</b>   |  | 17d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 17e. STREET ADDRESS <b>2902 Louise Ave., 21214</b>  |  |
| 18. FATHER'S NAME FIRST MIDDLE LAST <b>Charles W. Nagle</b>   |  |   |  |   | 19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Katherine Distlebart</b> |  |  |   |  |
| 20a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>  |  |   |  |   | 20b. SOCIAL SECURITY NO. <b>218-05-1565</b>                            |  |  |   |  |
| 20c. ADDRESS <b>Rev. Alan W. Nagle, 8305 BT Loch Raven Blvd.</b>  |  |   |  |   |  |  |  |   |  |
| 21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY ARREST</b> 4413   |  |   |  |   |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b>RUPTURED ABD. AORTIC ANEURYSM</b> 10 HOURS  |  |   |  |   |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</b>  |  |   |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>-</b>  |  |   |  |   |  |  |  |   |  |
| 22a. DATE OF OPERATION <b>1/19/83</b>   |  |   | 22b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>ABD. AORTIC ANEURYSM</b> |   |  | 22c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 22d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   | 23b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>                       |   |  | 23c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                |  |   |  |
| 24a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 24b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)          |   |  | 24c. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 25. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>1/18</b> , 19 <b>83</b> , to <b>1/19</b> , 19 <b>83</b> , that (I) <b>(the)</b> last saw the deceased alive on <b>1/19</b> , 19 <b>83</b> , and that in (my) <b>(the)</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>(do)</b> (did) (deem) view the body after death. |  |   |  |   |  |  |  |   |  |
| 26a. SIGNATURE <b>Randall Riegler</b>   |  |   |  |   | 26b. DEGREE <b>M.D.</b>  |  |  | 26c. DATE SIGNED <b>1/19/83</b>   |  |
| 26d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RANDALL RIEGLER M.D.</b>   |  |   |  |   | 26e. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>                            |  |  |   |  |
| 27a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  |   | 27b. DATE <b>1/22/83</b>   |   |  | 27c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Ceme.</b>                                  |  | 27d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. City Md.</b>  |  |
| 28. FUNERAL DIRECTOR <b>J. E. Lowell Lemmon</b>   |  |   |  |   | 28a. DATE REC'D. BY REGISTRAR <b>JAN 25 1983</b>                       |  |  |   |  |
| 28b. ADDRESS <b>10 W. Padonia Rd.</b>   |  |   |  |   | 28c. REGISTRAR'S SIGNATURE <b>John J. Conner</b>                       |  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. UNIT NO. 6682920   |  |  |  |
|--|--|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Thomas A. Naidus  |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>1 7 83   |  |   |  | 2b. HOUR<br>6:52 AM  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 15 10   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(COUNTRY)<br>NEW JERSEY  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. CITY MD.  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MACHINIST  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>CROWN CORK & SEAL                    |  |  |  |
| 13a. STATE<br>md.  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>3801 Schnapper Dr. 21133                           |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>UNKNOWN  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>UNKNOWN   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES  |  |   |  | 16b. SOCIAL SECURITY NO.<br>WWII<br>293-01-0274   |  | 17. INFORMANT<br>ADDRESS<br>Rose C. NAIDUS (SAME)  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac Arrest<br>1629<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost:<br>(b) Cancer of Lung = Multiple metastases<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5:38 - 5:58  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/30, 1982, to 1/7, 1983, that (I) (we) last saw the deceased alive on 1/7, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                 |  |   |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>B. Roeder PA   |  |   |  |   |  | DEGREE J. M. PARRY, M.D.<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br>1/6/83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>B. Roeder PA  |  |   |  |   |  | 22e. ADDRESS<br>SINAI HOSPITAL   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  |   |  | 23b. DATE<br>1-10-83  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GRUIN RIDGE CEM.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Pikesville BALTO. MD.       |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>FRANK H. NEWELL, INC.  |  |   |  |   |  | ADDRESS<br>1100 KEISTER TOWN RD.   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 11 1983                              |  | 25b. REGISTRAR'S SIGNATURE<br>John G. Pruitt   |  |

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DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

|  |  |   |   |
|--|--|---|---|
| 1. FOR STATE REGISTRAR   |  | REG. NO.  |   |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JAMES A. NEDDOFF</b>   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>01 07 1983</b> 2b. HOUR<br><b>4:55P</b>  |   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 2 39</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>43</b> YRS.<br>IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pa.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b>          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Superintendent</b>  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>schools</b>   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Pa.</b>   |  | 13b. CITY OR TOWN<br><b>Chester</b>   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Abraham Nedoff</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anne Kurkas</b>   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)<br><b>No</b>   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>179-30-5036</b>  | 17. INFORMANT ADDRESS<br><b>Linda Nedoff (same as 13e)</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>2050 IMMEDIATE CAUSE (a) Acute Myelocytic Leukemia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>11/22/82 - 1/7/83</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |   |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/24</b> 19 <b>82</b> , to <b>1/7</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1/7</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.      |  |   |   |
| 22b. SIGNATURE<br><b>J. Niles</b>  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1/7/83</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John Niles</b>   |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)<br><b>Burial</b>  | 23b. DATE<br><b>1/11/83</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Mary's Cemetery</b>  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Hanover Pa.</b>  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Balto., Md. 21225<br/>George J. Gome F.N. 4001 Ritchie Hgwy.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 10 1983</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>   |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |  |  |  |  | 8 3 0 1 2 2 6  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  |  |  |  |  |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |  |  | 3. SEX                                 |  |  |  |  | 2a. DATE OF DEATH  |  |
| FIRST MIDDLE LAST<br><i>Philip Needle</i>  |  |  |  |  | MALE                                   |  |  |  |  | MONTH DAY YEAR<br><i>1/1/83</i>                                |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  |  |  | 9. AGE (IN YEARS LAST BIRTHDAY)        |  |  |  |  | 2b. HOUR   |  |
| MARYLAND   |  |  |  |  | 80 YRS                                 |  |  |  |  | <i>5:12 A.M.</i>   |  |
| 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  | 5. DATE OF BIRTH                       |  |  |  |  | 12b. HOUR  |  |
| USA  |  |  |  |  | MONTH DAY YEAR<br><i>NOV. 21, 1902</i> |  |  |  |  | <i>5:12 A.M.</i>   |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)        |  |  |  |  | 12b. HOUR  |  |
| <i>Baltimore city</i>  |  |  |  |  | 80 YRS                                 |  |  |  |  | <i>5:12 A.M.</i>   |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |  | 12b. HOUR  |  |
| (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>N. CHARLES GEN. HOSP.</i>   |  |  |  |  | <i>Baltimore city</i> MD.              |  |  |  |  | <i>5:12 A.M.</i>   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY      |  |  |  |  | 12b. HOUR  |  |
| OWNER  |  |  |  |  | REAL ESTATE                            |  |  |  |  | <i>5:12 A.M.</i>   |  |
| 13a. STATE   |  |  |  |  | 13b. CITY OR TOWN                      |  |  |  |  | 13c. STREET ADDRESS  |  |
| MARYLAND   |  |  |  |  | BALTIMORE                              |  |  |  |  | APT. 811<br><i>3900 N. CHARLES ST. #21218</i>                  |  |
| 14. FATHER'S NAME  |  |  |  |  | 15. MOTHER'S MAIDEN NAME               |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                   |  |
| FIRST MIDDLE LAST<br><i>SIMON NEEDLE</i>   |  |  |  |  | FIRST MIDDLE LAST<br><i>LENA BAER</i>  |  |  |  |  | (IF YES, GIVE WAR OR DATES)                                    |  |
| 16b. SOCIAL SECURITY NO.   |  |  |  |  | 17. INFORMANT                          |  |  |  |  | 17. ADDRESS  |  |
| 219-28-7716  |  |  |  |  | MRS. DORA G. NEEDLE                    |  |  |  |  | <i>3900 N. CHARLES ST., APT. 811 #21218</i>                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiogenic shock</i>   |  |  |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute myocardial infarction</i>  |  |  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |  |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY                              |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |  |
|  |  |  |  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19              |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED   |  |  |  | 21e. PLACE OF INJURY                             |  |  |  | 21f. LOCATION  |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  |  | STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/30/82</i> to <i>1/1/83</i> , that (I) (we) last saw the deceased alive on <i>1/1/83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED   |  |
| <i>Marcos B. Galicia Jr. MD</i>  |  |  |  |  |  |  |  |  |  | <i>1/1/83</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS   |  |
| MARCO B. GALICIA JR. MD  |  |  |  |  |  |  |  |  |  | North Charles Gen. Hospital                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  | 23b. DATE  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |
| BURIAL   |  |  |  | JAN. 3, 1983                                     |  |  |  | ANSHE EMUNAH-AITZ CHAIM  |  |  |  |
| 23d. LOCATION  |  |  |  | 23e. DATE REC'D. BY REGISTRAR                    |  |  |  | 23f. REGISTRAR'S SIGNATURE   |  |  |  |
| CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND  |  |  |  | JAN 6 1983                                       |  |  |  | <i>John J. Connel</i>  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  |  |  |  |  |  |  |
| NAME ADDRESS<br>SO. L. LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215  |  |  |  |  |  |  |  |  |  |  |  |

BP



100 (198) 100

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8301227

REG. NO.

|   |  |  |  |                        |  |
|---|--|--|--|------------------------|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |  | 2b. HOUR               |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 2a. DATE OF DEATH  |  | 2b. HOUR               |  |
| FIRST MIDDLE LAST   |  | MONTH DAY YEAR   |  | HOURS MIN.             |  |
| Donna M. Nelson   |  | 1/18/83  |  | 5:22 PM                |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                | IF UNDER 1 YEAR        |  |
| male  | Black  | MONTH DAY YEAR   | 50 YRS.  | MONTHS DAYS HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |                        |  |
| S. Carolina   | U.S.A.   |  | Baltimore City, MD.  |                        |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY                              |                        |  |
| Baltimore   | Baltimore City Hospital  |  |  |                        |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13d. INSIDE CITY LIMITS?   | 13e. STREET ADDRESS  |                        |  |
| 13a. STATE  | 13b. COUNTY  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 21217  |                        |  |
| Maryland  |  |  | 2204 Pennsylvania Ave.   |                        |  |
| 14. FATHER'S NAME   | 15. MOTHER'S MAIDEN NAME   | ADDRESS  |  |                        |  |
| FIRST MIDDLE LAST   | FIRST MIDDLE LAST  |  |  |                        |  |
| Henry Nelson  | Eliza Oliver   |  |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   | 16b. SOCIAL SECURITY NO.   | 17. INFORMANT  |  |                        |  |
| No  | 250-52-5414  | Helen Jones 623 George St.-A   |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |  |                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a)   |  |  |  |                        |  |
| 8903 Cardiac Arrest   |  |  |  |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)  |  |  |  |                        |  |
| Metabolic Acidosis  |  |  |  |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |                        |  |
| Renal Failure / Hypertension  |  |  |  |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |  |                        |  |
| Sepsis  |  |  |  |                        |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                        |  |
| MULTIPLE  | Burns  | YES <input type="checkbox"/> NO <input type="checkbox"/>   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |                        |  |
|   | HOUR A.M. MONTH DAY YEAR   | House Fire   |  |                        |  |
|   | P.M. 10 16 83  |  |  |                        |  |
| 21d. INJURY OCCURRED  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION  |  |                        |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | STREET CITY OR TOWN COUNTY STATE   |  |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 10, 1982, to Jan 18, 1983, that (I) (we) last saw the deceased alive on Jan 18, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |                        |  |
| 22b. SIGNATURE  | DEGREE   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED       |  |
| Jeffrey H. Peters   |  |  |  | 1/18/83                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   | 22e. ADDRESS   |  |  |                        |  |
| Jeffrey H. Peters   | 610 N. Broadway, Balt. Md.   |  |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL   | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY   | 23d. LOCATION  |                        |  |
| BURIAL  | 1/24/83  | Mount Zion Cem.  | Baltimore Co. Md.  |                        |  |
| 24. FUNERAL DIRECTOR  |  | 25. REG. BY REGISTRAR?   |  |                        |  |
| NAME  |  | REGISTRAR'S SIGNATURE  |  |                        |  |
| Wm. C. March F/H Inc 1101 E. North Avenue   |  | JAN 21 1983 John J. Carney   |  |                        |  |



NOV 10 1963

RECEIVED  
OCT 15 1963

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(V) R A15 ME (5)  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |              |  |   |   |   |  |   |  | REG. NO. 01228   |  |
|--|--|--------------|--|---|---|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |              |  |   |   |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Helen Elizabeth M. Nicholas Nichols  |  |              |  |   |   |   |  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR<br>1 1 1983 |  |
| 3 SEX<br>F   |  | 4. RACE<br>W |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>12 9 18  |   | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>64                                    |  | IF UNDER 1 YR. MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br>1 1 1982                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   |  |              |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD                             |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |              |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>412 Old Orchard Road |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Cor. Eng. - Cor. U. S. Army  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Md.  |  |              |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>Balto., Md. #21229<br>412 Old Orchard Rd.                       |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>G. Leroy Nichols  |  |              |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Gertrude Thompson |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  |              |  | 16b. SOCIAL SECURITY NO.<br>220-14-2037   |   |   |  | 16c. ADDRESS<br>Bun. Bldg. 20 S. Calver St. Balto.,<br>Mr. Z. Townsend Parks, Jr. Md. 21201   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4292 Arteriosclerotic Cardiovascular Disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |              |  |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |              |  |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |              |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |   | 21f. LOCATION CITY OR TOWN COUNTY STATE                                       |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |              |  |   |   |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br>Dennis F. Smyth M.D.   |  |              |  | TITLE (SPECIFY)<br>Assistant MEDICAL EXAMINER   |   |   |  | DATE SIGNED<br>1-1-83   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Dennis F. Smyth, M.D.   |  |              |  | ADDRESS<br>111 Penn Street  |   |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |              |  | 23b. DATE<br>1-5-83   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cem.                        |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Balto. Md.                                  |  |
| 24. FUNERAL DIRECTOR<br>G. Leuman Schwab   |  |              |  | ADDRESS<br>5151 Balto. Nat'l. Pike #21229   |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 7 1983   |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Connelley  |  |

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  | 8 3 0 1 2 2 9 |  |
|---|--|--|--|---|--|--|--|--|--|---------------|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   |  |  |  |  |  | REG. NO.      |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ROGER NICHOLSON</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 21 83</b>                                |  | 2b. HOUR<br><b>9:40A M</b>   |  |               |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>NEGRO</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JAN. 5 1914</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NORTH CAROLINA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US of A</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                    |  |  |  |               |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>VAMC LOCH RAVEN BLVD. BALTO MD</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CLEANERS</b>   |  |               |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  |  |  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ULYSSES NICHOLSON</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LILLIAN BUSTIN</b>  |  |  |  |  |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II 238 07 8827</b>              |  | 17. INFORMANT<br>ADDRESS<br><b>MRS. LILLIE MAE TURNER 738 N. FULTON AVE. 21217</b>  |  |  |  |  |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1509 IMMEDIATE CAUSE (a) Cardio pulmonary arrest</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>esophageal carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>months</b><br><b>Months</b>   |  |               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |  |  |               |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                           |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |               |  |
| 22a. I certify that <del>XX</del> (his) hospital attended the deceased from <b>January 14, 1983</b> , to <b>January 21, 1983</b> , that <del>X</del> (we) last saw the deceased alive on <b>January 21, 1983</b> , and that in <del>(X)</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>X</del> (we) (did) <del>(did not)</del> view the body after death. |  |  |  |   |  |  |  |  |  |               |  |
| 22b. SIGNATURE<br><b>Joseph M. Reilly</b>   |  |  |  | DEGREE<br><b>M.D.</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br><b>1/21/83</b>   |  |               |  |
| 22d. PHYSICIAN'S NAME<br><b>JOSEPH M. Reilly</b>  |  |  |  | 22e. ADDRESS<br><b>3900 Loch Raven Blvd. Balto. Md</b>  |  |  |  |  |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>1/25/83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ENFIELD MEMORIAL CEM.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ENFIELD (HALIFAX) N. C.</b>         |  |  |  |               |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>LEWIS T. GWYNN 4517 PARK HEIGHTS AVENUE</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 24 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                                  |  |  |  |               |  |

BP



NAME

ORDER

JAN. 5 1914

CO

US OF A

NORTH CAROLINA

X

UNITED

GERMANY

2152

2015 LAMAR AVENUE

X

BALTIMORE

WILMINGTON

NICHOLSON

LILLIAN

BUTLER

2157

MRS. LILLIAN NICHOLSON 238 W. FULTON ST.

NO 11

24

COPIES  
1/15/14



1/25/14

DO NOT

RECEIVED JAN 25 1914

RECEIVED JAN 25 1914

RECEIVED JAN 25 1914

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 2 3 0

FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Helene Ida Niegsch                  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 8, 1983 |   |  | 2b. HOUR<br>8:50P M   |  |  |  |
| 1. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan 29, 1895  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Germany                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>General German Aged Peoples Home |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Nurse                       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Retired   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>---  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>4648 Colherne Rd. 21229 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Paul H Niegsch                   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Auguste Mattesius  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>---  |  | 17. INFORMANT<br>22 S. Athol<br>General German Aged Peoples Home  |  | ADDRESS<br>Balto, Md. 21229   |  |  |  |

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|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4140<br>DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis<br>Cerebral arteriosclerosis & Thrombosis<br>DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic heart disease |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
|--|--|---|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8 Jan 1980 to 8 Jan 1983, that (I) (we) lost saw the deceased alive on 8 Jan 1983 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>William J. Bryson M.D.  |  |  |  | DEGREE<br>M.D.   |  | 22c. DATE SIGNED<br>1-10-83   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. William J. Bryson  |  |  |  | 22d. ADDRESS<br>5772 Westview Mall 21228   |  |   |  |

MEDICAL CERTIFICATION

|  |  |                      |  |  |  |  |  |
|--|--|----------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |  | 23b. DATE<br>1-10-83 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Memorial Pk |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Catonsville Baltimore MD |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Loring Byers Funeral Directors, Inc.<br>8728 Liberty Rd. Randallstown, Md. 21133 |  |                      |  | 25. DATE REC'D. BY REGISTRAR<br>JAN 11 1983                |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 7 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |   |  |   |  |  |  |
|--|--|--|--|---|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  | REG. NO. 83 01231  |   |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>DOROTHY R. NORRIS</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>1/2/83</b>                        |   |   | 2b. HOUR<br><b>1015 P.M.</b>   |   |  |  |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>07 02 23</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIVERSITY OF MARYLAND</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>clerical</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Paul Ins. Co.</b>        |  |  |
| 13a. STATE<br><b>MD.</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  | 13e. STREET ADDRESS<br><b>CUB HILL APARTMENTS</b><br><b>1 Lava Ct. Apt. 2A</b><br><b>21234</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HUGH</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>JULIETTE NICHOLS</b> |   |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>UNK</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>217-24-6167</b>                           |   | 17. INFORMANT<br>ADDRESS<br><b>Kevin M. Norris</b><br><b>1 Lava Ct. Apt. 1A</b><br><b>Balto., Md. 21234</b> |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4300 IMMEDIATE CAUSE (a) CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>RESPIRATORY ARREST</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) <b>PNEUMONIA, SEPSIS</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>8 DAYS</b> |  |  |  |   |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>MASSIVE CEREBRAL INFARCT SECONDARY TO SUBARACHNOID HEMORRHAGE</b>  |  |  |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>12/13/82</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>LEFT POSTERIOR COMMUNICATING ARTERY ANEURYSM</b>                                    |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |  |  |  |
| 22a. I certify that (I) (his hospital) attended the deceased from <b>1/2</b> 19 <b>83</b> , to <b>1/2</b> 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>1/2</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.   |  |  |  |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Edward S. Holt</b>  |  |  |  | DEGREE<br><b>MD</b>   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1/2/83</b>                                |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>EDWARD S. HOLT</b>   |  |  |  | 22e. ADDRESS<br><b>UNIVERSITY OF MD. HOSPITAL</b>   |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1-5-83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Lassahn Funeral Home 7401 Belair Rd.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 10 1983</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>  |   |  |  |  |

BP





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 2 3 2

FOR  
1- STATE  
REGISTRAR

REG. NO.

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Walter B. Norris   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>01 02 83                                    |  | 2b. HOUR<br>7:55 A.M.  |
| 3. SEX<br>Male  | 4. RACE<br>Caucasian   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 10 17  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS                                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY)<br>MD  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore city MD.                         |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Bal. Gen. Hosp. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Auto. Mechanic | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>4D.   |  |   | 13b. COUNTY<br>---   | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Benjamin ----- Norris   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lorina ----- Hawkins              |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>53-15-0099<br>53-15-199   |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Dorothy M. Norris, Same as above              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac arrest<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Heart Block<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) Possible Acute MI |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-1-1983, to 1-2-1983, that (I) (we) lost<br>saw the deceased alive on 1-2-83 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death.                            |  |   |  |  |  |
| 22b. SIGNATURE<br>(DMD)   |  | DEGREE  |  | 22c. DATE SIGNED<br>1-2-83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Omar E. Mender, M.D.   |  | 22e. ADDRESS<br>South Baltimore General Hosp.   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>Jan. 5, 1983  | 23c. NAME OF CEMETERY OR CREMATORY<br>Western Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>McCurly Funeral Home, 130 E. Fort Ave. Balto. Md.   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 4 1983   |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Currier                                  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be continued by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 01233

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>EDITH</b> <b>NUGENT</b>  |   |   | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>9</b> YEAR <b>83</b>                                 |   | 2b. HOUR<br><b>12:10 P.M.</b>                   |
| 3. SEX<br><b>F.</b>   | 4. RACE<br><b>NEGRO</b>   | 5. DATE OF BIRTH<br>MONTH <b>6</b> DAY <b>26</b> YEAR <b>97</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS.                         |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.         |   |
| 10. CITY OR TOWN OF DEATH<br><b>city</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>San Decours</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Domestic</b>             | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>md</b> 13b. COUNTY <b>BALTO</b> 13c. CITY OR TOWN <b>BALTO</b>  |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |   |
| 14. FATHER'S NAME<br>FIRST <b>Wm.</b> MIDDLE <b>JOHNSON</b> LAST <b></b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Georgiana</b> MIDDLE <b>Robinson</b> LAST <b></b>          |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br>ADDRESS<br><b>Sylvia Ali 706 E. 20th ST</b>              |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1889</b> IMMEDIATE CAUSE (a) <b>Cancer of Bladder - metastasis</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>Senile dementia</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <b></b>   |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b></b>  |   |   |   |   |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)    |   |   |   |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                         |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/8</b> 19 <b>83</b> , to <b>1/9</b> 19 <b>83</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/8</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |   |   |   |   |   |
| 22b. SIGNATURE<br><b>Kuang-yen Huang</b>  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br><b>1/9/83</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KUANG-YEN HUANG</b>   |   | 22e. ADDRESS<br><b>Bon Secours Hosp</b>   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>1/13/83</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn</b>                   |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO - MD</b>   |   | 24. FLUNERAL DIRECTOR<br><b>Locke Funeral Home 1304 N. Central St</b>   |   |   |   |
| 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 11 1983</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conish</b>   |   |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



|   |   |  |  |                                |   |
|---|---|--|--|--------------------------------|---|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Elizabeth R. Nuttall                       |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>1/13/83  |                                | 2b. HOUR<br>340 P.M.  |
| 3 SEX<br>Female   | 4 RACE<br>Cauc.   | 5 DATE OF BIRTH MONTH DAY YEAR<br>Nov. 28, 1930  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>52 YRS.  |                                | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Delaware   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                |                                |   |
| 10 CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife               |                                | 12b. KIND OF BUSINESS OR INDUSTRY<br>-----  |
| 13a. STATE<br>Maryland  |   |  | 13b. COUNTY  | 13c. CITY OR TOWN<br>Baltimore | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Isaac H. Beideman  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Clara Bartels                              |                                |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No |   | 16b. SOCIAL SECURITY NO.<br>221 26 7615  | 17. INFORMANT ADDRESS<br>3407 Cranston Ave., Wilm., Del.<br>Andrew H. Beideman (Brother) |                                |   |

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|---|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Collapse</u><br>4310<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Interventricular hemorrhage</u><br>(c) <u>Interventricular hemorrhage</u><br>DUE TO, OR AS A CONSEQUENCE OF |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

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| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>hypertension, mitral stenosis, chronic anticoagulation</u>   |   |  |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/7, 1983, to 1/12, 1983, that (I) (we) last saw the deceased alive on 1/13, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. |   |  |  |
| 22b. SIGNATURE <u>[Signature]</u> DEGREE   |   | 22c. DATE SIGNED 1/13/83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Lloyd Stahl   |   | 22e. ADDRESS<br>Balt City Hospital   |  |

|  |                      |   |   |
|--|----------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                          | 23b. DATE<br>1/19/83 | 23c. NAME OF CEMETERY OR CREMATORY<br>Gracelawn Mem. Pk                                     | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Wilmington N. C., Del. |
| 24 FUNERAL DIRECTOR<br>Albert J. McCrery, III, 3924 Concord Pk., Wilm., Del. |                      | 25a. DATE RECEIVED BY REGISTAR JAN 18 1983<br>25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpaper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

FROM THE DIRECTOR OF THE BUREAU OF THE CENSUS

WASHINGTON, D. C. 20543

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  | REG. NO. |  |
|---|--|--|--|---|--|--|--|--|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Anna Agatha O'Connor</i>   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>1 10 83</i>                                |  | 2b. HOUR<br><i>8<sup>10</sup> PM</i>   |  |          |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>White</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>4 9 96</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>86</i>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Germany</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                    |  |  |  |          |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Mason F. Lord Bldg</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Retired</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Housework</i>  |  |          |  |
| 13a. STATE<br><i>md</i>   |  | 13b. COUNTY<br>-----   |  | 13c. CITY OR TOWN<br><i>Baltimore</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>3221 Dillon St.</i>  |  |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Robert Agatha</i>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Frieda ?</i>  |  |  |  |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>218-0902475</i>   |  | 17. INFORMANT ADDRESS<br><i>Anna O. Heffernan 6833 Boston Ave. 21222</i>  |  |  |  |  |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cerebrovascular accident</i><br><i>4360</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>1 MO</i> |  |  |  |   |  |  |  |  |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>Diabetes mellitus</i>  |  |  |  |   |  |  |  |  |  |          |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NO! WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Dec 11</i> , 19 <i>82</i> , to <i>Jan 10</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>Jan 10</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |  |  |          |  |
| 22b. SIGNATURE<br><i>John R. Burton</i> MD  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br><i>Jan 11, 1983</i>  |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>JOHN R. BURTON</i>  |  |  |  | 22e. ADDRESS<br><i>5200 EASTERN AVE 21224</i>   |  |  |  |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>1-16-83</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Holy Rosary</i>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Dundalk, Balto. Co., Md.</i>        |  |  |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>C.S. Zeiler &amp; Son Inc. 901 S. Conkling Street</i>  |  |  |  | ADDRESS<br><i>21224</i>   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 12 1983</i>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Joan J. Connelley</i>   |  |          |  |

BP





11.7.71  
James  
Robert  
218-00-7175  
James (The Bureau 6833) Boston Va. 21-22

1-1-73  
James  
James (The Bureau 6833) Boston Va. 21-22

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 2 3 6

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |  |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CONNIE L. O'CONNOR</b>  |  |  | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>13</b> YEAR <b>83</b> |   |  | 2b. HOUR<br><b>7:25</b> P.M.   |  |  |  |  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>09</b> DAY <b>20</b> YEAR <b>05</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.      |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>GEORGIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MERCY HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>BUS DRIVER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>MASS TRANSIT</b>                     |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>---</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>2567 MARBOURNE AVENUE, 21230</b>                   |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>O.</b> MIDDLE <b>GARNER</b> LAST <b>GARNER</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>MARTHA</b> MIDDLE <b>J.</b> LAST <b>HUGGINS</b>  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>220-01-3467</b>   |  | 17. INFORMANT<br><b>WILLIAM B. O'CONNOR</b>   |  | ADDRESS<br><b>2567 MARBOURNE AVENUE</b>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4254</b> IMMEDIATE CAUSE (a) <b>Congestive cardiomyopathy</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                 |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Renal failure</b>  |  |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>1/13/83</b>  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>    |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/13/83</b> to <b>1/13/83</b> , that (I) (we) last saw the deceased alive on <b>1/13/83</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we do not view the body after death.)  |  |  |  |   |  |  |  |  |  | 22c. DATE SIGNED<br><b>1/13/83</b>   |  |
| 22b. SIGNATURE<br><b>A. Reisinger M.D.</b>  |  |  |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A. REISINGER, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>MERCY HOSPITAL</b>   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>ENTOMBMENT</b>  |  |  |  | 23b. DATE<br><b>01-17-83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK MAUSOLEUM</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b> |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>   |  |  |  | ADDRESS<br><b>4107 WILKENS AVE.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 17 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                          |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MARIE R O'CONNOR              |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 8 83                               |  | 2b. HOUR<br>9:45 AM  |
| 3. SEX<br>Female   | 4. RACE<br>CAUC White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug 20, 1904  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 78 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                               | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired | 12b. KIND OF BUSINESS OR INDUSTRY<br>Secretary                                       |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Howard   | 13c. CITY OR TOWN<br>Ellicott City  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>late Michael Bayer         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>late Augusta Pranke  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>219 22 6250  |   | 17. INFORMANT ADDRESS<br>William Russ 8005 Nottingham Way 21043                      |  |

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>1991 IMMEDIATE CAUSE (a). CARDIOPULMONARY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) UNDERLYING DIFFUSE INTERSTITIAL LUNG DISEASE 20yrs<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) POSSIBLE DRUG RXN. CA. INFECTION |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c).<br>COMPROMISED CARDIOVASC STATUS - SP MI X2, HX CHF ARTERYHIALS ACUTE   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21a. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21a. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21i. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/8 1983 to 1/8 1983, that (I) (we) lost saw the deceased alive on 1/8 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                           |  |  |  |  |  |
| 22b. SIGNATURE<br>Georgia R. Hsieh MD  |  |  |  | 22c. DATE SIGNED<br>1/8/83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GEORGIA R. HSIEH MD   |  |  |  | 22e. ADDRESS<br>22 S. GREENE ST.   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |  | 23b. DATE<br>Jan 10, 1983  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Memaorila Pk                          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Harry H Witzke   |  | 24b. ADDRESS<br>4112 Columbia Road Ellicott City                       |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 11 1983   |  |
| 25b. REGISTRAR'S SIGNATURE<br>John J. Connel   |  |  |  |  |  |



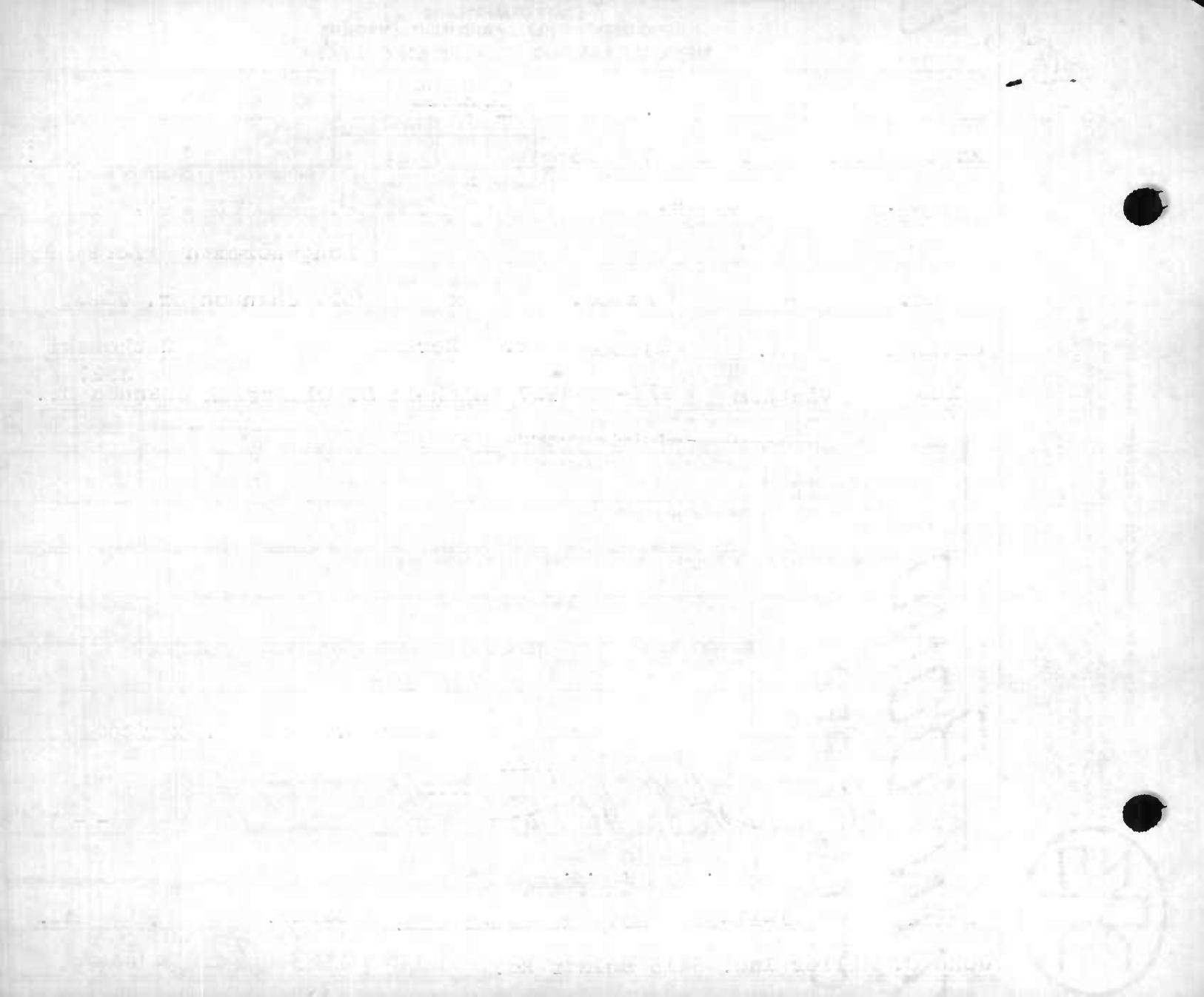
Marjorie Howard  
Baltimore  
University Hospital  
Baltimore  
Secretary  
Baltimore City  
U.S.A.  
Marjorie Howard  
Baltimore  
University Hospital  
Baltimore  
Secretary  
Baltimore City  
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Secretary  
Baltimore City  
U.S.A.  
Marjorie Howard  
Baltimore  
University Hospital  
Baltimore  
Secretary  
Baltimore City  
U.S.A.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |              |  |  |  |  |  |  |  |                          | REG. NO. 01238   |  |             |
|--|--------------|--|--|--|--|--|--|--|--------------------------|--|--|-------------|
| 1- FOR STATE REGISTRAR   |              |  |  |  |  |  |  |  |                          | 2a. DATE KNOWN OF DEATH  |  | 2b. HOUR    |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edward V. Oleszczuk Oleszczuk   |              |  |  |  |  |  |  |  |                          | MONTH DAY YEAR 1 7 1983  |  | 10.42 a. M. |
| 3. SEX Male  | 4. RACE Cau. | 5. DATE OF BIRTH MONTH DAY YEAR 8 2 47   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 35 YRS.                          | IF UNDER 1 YR. MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.                              |  | 2c. DATE PRONOUNCED DEAD | 2d. HOUR   |  |             |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.  |              | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. |  | 10.42 a. M.              |  |  |             |
| 10. CITY OR TOWN OF DEATH Baltimore  |              | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3527 Shannon Drive |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Longshoreman                     |  | 12b. KIND OF BUSINESS OR INDUSTRY Local 950        |                          |  |  |             |
| 13a. STATE Md.   |              | 13b. COUNTY -  |  | 13c. CITY OR TOWN Balto.   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS 3527 Shannon Dr. 21213         |                          |  |  |             |
| 14. FATHER'S NAME FIRST MIDDLE LAST Casimir A. Oleszczuk Sr.   |              |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Rutkowski  |  |  |  |                          |  |  |             |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes   |              |  |  | 16b. SOCIAL SECURITY NO. Vietnam                                 |  | 17. INFORMANT ADDRESS 3527 Michele A. Oleszczuk Shannon Dr.                                    |  |  |                          |  |  |             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple Gunshot Wounds (Handgun)<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |              |  |  |  |  |  |  |  |                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |             |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |              |  |  |  |  |  |  |  |                          |  |  |             |
| 19a. DATE OF OPERATION   |              |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                |  |  |  |  |                          | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |             |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |              |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 7 1983       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) subject was shot |  |  |                          |  |  |             |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |              |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3527 Shannon Dr., Baltimore, Maryland           |  |  |                          |  |  |             |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |              |  |  |  |  |  |  |  |                          |  |  |             |
| ACTUAL SIGNATURE Dennis F. Smyth M.D.  |              |  |  | TITLE (SPECIFY) Assistant  |  |  |  | MEDICAL EXAMINER                                   |                          | DATE SIGNED 1-7-83   |  |             |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.  |              |  |  | ADDRESS 111 Penn Street  |  |  |  |  |                          |  |  |             |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |              | 23b. DATE 1-11-83  |  | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.            |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md. |                          |  |  |             |
| 24. FUNERAL DIRECTOR NAME John C. Miller Inc.  |              |  |  |  |  | ADDRESS 6415 Belair Rd.  |  | 25a. DATE REC'D. BY REGISTRAR JAN 10 1983          |                          | 25b. REGISTRAR'S SIGNATURE John J. Connel  |  |             |

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 2 3 9

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |  |                                    |  |   |  |                            |  |  |
|--|--|---|--|--|------------------------------------|--|---|--|----------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST MIDDLE LAST  |  |                                    | 2a. DATE OF DEATH MONTH DAY YEAR   |   |  |                            | 2b. HOUR                                     |  |
| CATALINO — OMBADO  |  |   |  |  |                                    | F 1 10 83  |   |  |                            | 6:02 PM                                      |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH   |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)  |   |  |                            | 7. IF UNDER 1 YEAR                           |  |
| Male   |  | Oriental  |  | 3 25 1897  |                                    | 85 YRS.  |   |  |                            | MONTHS DAYS HOURS MIN                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |  |                            |  |  |
| Philippines  |  | U.S.A.  |  |  |                                    | Baltimore City MD.   |   |  |                            |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |                                    | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |   |  |                            | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| Baltimore  |  | South Balto. Gen. Hosp.   |  |  |                                    | Cook on a Ship   |   |  |                            |  |  |
| 13a. STATE   |  |   | 13b. COUNTY  |  | 13c. CITY OR TOWN                  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS        |  |  |
| MD.  |  |   |  |  | Baltimore                          |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 27 South ANN Street. 21224 |  |  |
| 14. FATHER'S NAME  |  |   | 15. MOTHER'S MAIDEN NAME   |  |                                    |  |   |  |                            |  |  |
| Julien   |  |   | OMBAD.   |  |                                    | JUANITA — SIMMANIAND   |   |  |                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS              |  |   |  |                            |  |  |
| No   |  |   | 217-20-7912  |  | Mary Woodward 2906 Alvarado Sq.    |  |   |  |                            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MASSIVE BILATERAL BRONCHOPNEUMONIA<br>4960<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) C.O.P.D.<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) DUE TO, OR AS A CONSEQUENCE OF |  |   |  |  |                                    |  |   |  |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |                                    |  |   |  |                            |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |                                    | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                            |  |  |
|  |  |   |  |  |                                    | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                            |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) |   |  |                            |  |  |
| 21d. INJURY OCCURRED   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |                            |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/16/82 to 1/10/83, that (I) (we) last saw the deceased alive on 1/10/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |                                    |  |   |  |                            |  |  |
| 22b. SIGNATURE   |  |   | DEGREE   |  |                                    | 22c. DATE SIGNED   |   |  |                            |  |  |
| Santayana  |  |   |  |  |                                    | 1/10/83  |   |  |                            |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   | 22e. ADDRESS   |  |                                    |  |   |  |                            |  |  |
| SANTAYANA  |  |   |  |  |                                    |  |   |  |                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |   | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                     |                            |  |  |
| Burial   |  |   | 1/14/83  |  | Oak Lawn Cem.                      |  |   | Baltimore Md.  |                            |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |  |   |  |  |                                    | 25a. DATE REC'D. BY REGISTRAR  |   |  | 25b. REGISTRAR'S SIGNATURE |  |  |
| B. Dabrowski & Son 2818 E. Baltimore St.   |  |   |  |  |                                    | JAN 12 1983  |   |  | John J. Casper             |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



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1950-1951

1950-1951

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
JAN 11 1983  
(VR 11/83 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8301240

|  |  |                         |  |  |  |  |  |   |  |  |  |   |  |                        |  |   |  |  |  |
|--|--|-------------------------|--|--|--|--|--|---|--|--|--|---|--|------------------------|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Lucille O'Neil</b>   |  |                         |  |  |  |  |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>1 4 1983</b> |  | 2b. HOUR<br><b>12:4</b>   |  |                        |  |   |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 15, 1927</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>55</b> |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS<br><b>0 0 0</b>  |  | 7. IF UNDER 24 HRS.<br>HOURS MIN<br><b>0 0</b>   |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>1 4 1983</b>                                   |  | 2d. HOUR<br><b>P M</b> |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                                   |  |                        |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2438 N. Howard Street</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                        |  |   |  |  |  |
| 13a. STATE<br><b>Mass.</b>   |  |                         |  | 13b. COUNTY<br><b>Roxbury</b>  |  |  |  | 13c. CITY OR TOWN   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                        |  | 13e. STREET ADDRESS<br><b>1050 Tremont Street 99999</b> |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Elijah Hutchinson</b>   |  |                         |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Julia Evans</b>   |  |  |  |   |  |                        |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>217-22-8669A</b>  |  |  |  | 17. INFORMANT ADDRESS<br><b>Sarah Stokes 2438 N. Howard Street</b>  |  |  |  |   |  |                        |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH          |  |                         |  |  |  |  |  |   |  |  |  |   |  |                        |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                         |  |  |  |  |  |   |  |  |  |   |  |                        |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |                        |  |   |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |   |  |                        |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |                        |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |  |  |  |  |  |   |  |  |  |   |  |                        |  |   |  |  |  |
| ACTUAL SIGNATURE<br><i>Margarita A. Korell</i>   |  |                         |  | TITLE (SPECIFY)<br><b>Assistant</b>  |  |  |  | M.D. <b>Assistant</b> MEDICAL EXAMINER  |  |  |  | DATE SIGNED <b>1/5/83</b>   |  |                        |  |   |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>  |  |                         |  | ADDRESS <b>111 Penn St., Balto. Md.</b>  |  |  |  |   |  |  |  |   |  |                        |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |                         |  | 23b. DATE<br><b>1/11/83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cemetery</b> |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                                   |  |   |  |                        |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E. North Avenue</b>   |  |                         |  | ADDRESS  |  |  |  | 25a. DATE REC'D BY REGISTRAR<br><b>JAN 10 1983</b>  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Connelley</i>  |  |                        |  |   |  |  |  |

THE UNIVERSITY OF CHICAGO  
DIVISION OF THE PHYSICAL SCIENCES  
DEPARTMENT OF CHEMISTRY

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|  |                  |  |   |   |   |
|--|------------------|--|---|---|---|
| 1- FOR<br>STATE<br>REGISTRAR   |                  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                          |   | 5301241<br>REG. NO.   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Clara F. Osbourn  |                  |  | 7a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> 1 4 19 83 |   | 2b. HOUR<br>M<br>4:00<br>P. M   |
| 2. SEX<br>FEMALE   | 4. RACE<br>WHITE | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>DEC. 22 1889 93 YRS.   | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>93 YRS.   | 7c. DATE<br>PRONOUNCED<br>DEAD<br>1 6 19 83                                   | 2c. HOUR<br>P. M  |
| 7b. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>Maryland   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City,                       |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1106 Quantrill Way |   | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br>SHIRT CO. |   |
| 13a. STATE<br>Maryland   |                  | 13b. COUNTY<br>Baltimore   |   | 12b. KIND OF BUSINESS<br>OR INDUSTRY<br>RETIRED                               |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>THOMAS C. OSBOURN  |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LAURA M. LEVI   |   | 13c. STREET ADDRESS<br>1106 QUANTRILL WAY                                     |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |                  | 16b. SOCIAL SECURITY NO.<br>212-104819   |   | 17. INFORMANT<br>ADDRESS<br>FAMILY RECORDS                                    |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |                  |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                     |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                  |  |   |   |   |
| 19a. DATE OF OPERATION   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                  |  |   |   |   |
| ACTUAL<br>SIGNATURE<br>Dennis F. Smyth M.D.  |                  | TITLE (SPECIFY)<br>Assistant   |   | DATE<br>SIGNED 1-7-83   |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Dennis F. Smyth, M.D.  |                  | ADDRESS<br>111 Penn Street   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |                  | 23b. DATE<br>JAN. 10, 1983   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>BALTIMORE CEM.                          |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Swans Funeral Chapel   |                  | ADDRESS<br>8800 HARFORD RD.  |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 18 1983                                  |   |
|  |                  |  |   | 25b. REGISTRAR'S SIGNATURE<br>Dennis F. Smyth                                 |   |



Page 1 of 1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |  |  | REG. NO.  |  |
|--|--|---|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Clarence R Ottey</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 1/10/83</b>   |  | 2b. HOUR<br><b>10:43 P.M.</b>                  |   |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Caucasian</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 26 13</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>11 14</b> |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto, MD</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto City</b> MD.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SBGH</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Truck Driver</b>  |  |   |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Balto</b>                               | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Clarence — Ottey</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b> |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN) <b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE LAST FOUR DIGITS)<br><b>W.W.11 212-03-1786</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Md. 21230</b><br><b>Gertrude Ottey, 2611 Wegworth Lane, Baltimore,</b>                                      |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>1991 Bronchopneumonia - Bilateral</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>cerecinomatosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 16</b> , 19 <b>82</b> , to <b>Jan 10</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>Jan 10</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |  |   |   |  |  |   |  |
| 22b. SIGNATURE<br><b>David Liskowicz</b>   |  | DEGREE  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/10/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>David Liskowicz</b>  |  | 22e. ADDRESS<br><b>SBGH, Harwood St. Baltimore MD 21230</b>   |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |  | 23b. DATE<br><b>1/14/1983</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>George J. Gonce, 4001 Ritchie Hwy., Baltimore, Md. 21225</b>  |  |   |   | 25a. DATE REC'D. BY REGISTRAR <b>JAN 13 1983</b> 25b. REGISTRAR'S SIGNATURE <b>John J. Liskowicz</b>                                       |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |   |   |   |  |  |  |
|---|--|--|--|--|---|---|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO. 8301243   |  |  |   |   |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Timothy ALLEN Overly</b>   |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 1 12 31 83 1225 AM                                 |   |   |  |  |  |
| 3. SEX Male   |  | 4. RACE Caucasian  |  | 5. DATE OF BIRTH MONTH DAY YEAR 1 20 65  |   | 6. AGE (IN YEARS LAST BIRTHDAY) 18 YRS.   |   | 7b. HOUR 1225  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO  |  | 7b. CITIZEN OF WHAT COUNTRY? USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.                           |   |  |  |  |
| 10. CITY OR TOWN OF DEATH BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mt. Washington Pediatric Hospital |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student               |   | 12b. KIND OF BUSINESS OR INDUSTRY School  |  |  |  |
| 13a. STATE Maryland   |  |  |  |  | 13b. CITY OR TOWN Pasadena  |   | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS 86 Johnson Rd. 21222   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Richard John Overly   |  |  |  |  | 15. MOTHER'S MAIDEN NAME MARIE SWINEFORD  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No  |  |  |  |  | 16b. SOCIAL SECURITY NO. 295-62-2488  |   | 17. INFORMANT (FATHER) ADDRESS RICHARD J. OVERLY Same As #13                      |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>3591 IMMEDIATE CAUSE (a) Respiratory Failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Duchenne's Muscular Dystrophy<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hours |  |  |  |  |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10   |  |  |  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/1 1982 to 1/31 1983, that (I) (we) lost saw the deceased alive on 1/30 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) did (did not) view the body after death.                               |  |  |  |  |   |   |   |  |  |  |
| 22b. SIGNATURE Constance R. Hiller, M.D.  |  |  |  |  | DEGREE  |   | 22c. DATE SIGNED 1/31/83  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Constance R. Hiller   |  |  |  |  | 22e. ADDRESS Mt. Washington Pediatric Hospital, 1708 W. Rogers Ave. Baltimore 21209 |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL  |  | 23b. DATE 2/3/83   |  | 23c. NAME OF CEMETERY OR CREMATORY ASHLAND CEM.  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE ASHLAND ASHLAND OHIO                      |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME E. BARNES ADDRESS 21018 BENSON, MD.   |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR FEB 4 1983  |   | 25b. REGISTRAR'S SIGNATURE John J. Conner   |  |  |  |



NAME

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RECEIVED

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL EXAMINER. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                                     |  |  |  |   |  |  |  | REG. NO. 01244   |  |
|---|--|-------------------------------------|--|--|--|---|--|--|--|--|--|
| 1- STATE REGISTRAR zip 20776  |  |                                     |  |  |  |   | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 31 1983 |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DANA LAMIER OWENS  |  |                                     |  |  |  |   | 2b. HOUR 2:25 P.M.   |  |  |  |  |
| 3. SEX Male   |  | 4. RACE Black                       |  | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 15-62   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 20 YRS.   |  | IF UNDER 1 YR. MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.   |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.                                     |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH Baltimore   |  |                                     |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION University Hospital   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodian                      |  | 12b. KIND OF BUSINESS OR INDUSTRY *****  |  |
| 13a. STATE Md.  |  |                                     |  | 13b. COUNTY A.A.   |  | 13c. CITY OR TOWN Harwood   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS 849 Harwood Rd. -20776                                       |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Kenneth L. Owens Sr.  |  |                                     |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy Ann Hall                                 |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No   |  |                                     |  | 16b. SOCIAL SECURITY NO. 213-82-7533   |  | 17. INFORMANT ADDRESS Kenneth L. Owens Sr. Same as 13E                                      |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>9654 IMMEDIATE CAUSE (a) Gunshot wound of head (unspecified weapon.)<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ |  |                                     |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                                     |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9 XXX 1-28-83   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject shot. |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 408 near Rt. 4 Anne Arundel Md.          |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion  |  |                                     |  |  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE [Signature]  |  |                                     |  | TITLE (SPECIFY) M.D. Assistant   |  |   |  | MEDICAL EXAMINER DATE SIGNED 2-1-83  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.  |  |                                     |  | ADDRESS 111 Penn St., Balto., Md. 21201  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  |                                     |  | 23b. DATE Feb. 4-83  |  | 23c. NAME OF CEMETERY OR CREMATORY Owens Family   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Harwood A.A. Md.                                     |  |  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS C.E. HICKS 111 Annapolis, Maryland  |  |                                     |  |  |  | 25a. DATE REC'D. BY REGISTRAR FEB 7 1983  |  | 25b. REGISTRAR'S SIGNATURE [Signature]   |  |  |  |



item 1 per phone 1/5/83 dad

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8301245

|   |  |  |  |
|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 2a. DATE OF DEATH  |  |
| FIRST MIDDLE LAST<br>SAMUEL OWENS   |  | MONTH DAY YEAR<br>1 2 83   |  |
| 3. SEX  |  | 2b. HOUR   |  |
| Male  |  | 9:10 AM  |  |
| 4. RACE   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |
| Black   |  | 74   |  |
| 5. DATE OF BIRTH  |  | IF UNDER 1 YEAR  |  |
| MONTH DAY YEAR<br>6 1 08  |  | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| North Car.  |  | CITY MD.   |  |
| 7b. CITIZEN OF WHAT COUNTRY?  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| USA   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |
| BALTIMORE   |  | Provident Hospital   |  |
| 13a. STATE  |  | 13b. CITY OR TOWN  |  |
| Md.   |  | Balto.   |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |
| FIRST MIDDLE LAST<br>John Owens   |  | FIRST MIDDLE LAST<br>Alice   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  |
| No  |  | 243-07-7661  |  |
| 17. INFORMANT   |  | ADDRESS  |  |
| Elizabeth Owens   |  | 4009 Grantly Ave.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| IMMEDIATE CAUSE (a) Respiratory failure   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |
| YES NO  |  | YES NO   |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  |
|   |  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |
| WHILE AT WORK NOT WHILE AT WORK   |  | 21f. LOCATION  |  |
|   |  | STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/2 19 83 to 1/2 19 83, that (I) (we) last saw the deceased alive on 1/2 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE  |  | 22c. DATE SIGNED   |  |
| M. A. RASHDAN   |  | 1/2/83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |
| M. A. RASHDAN   |  | 2600 LIBERTY RD  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  |
| Burial  |  | 1/6 /83  |  |
| 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION  |  |
| Arbutus Memorial Park   |  | Balto., Md.  |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |  |
| NAME ADDRESS<br>Leroy O. Dyett 4600 Liberty Hgts. Ave.  |  | 25b. REGISTRAR'S SIGNATURE   |  |
|   |  | IAN 31983 John J. Conner   |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Papers to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove &amp; retain papers, pages 1 and 2, should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 01246

REG. NO.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ELNOR OZAZEWSKI</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01/10/83</b>  |  | 2b. HOUR<br><b>11:58p</b>  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 1 1906</b>  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CHARWOMAN</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>MD NAT'L BANK</b>   |  | 13a. STREET ADDRESS<br><b>37 N CURLEY STREET</b>   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ANDREW DEMBECK</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>   |  | 16. SOCIAL SECURITY NO.<br><b>215 24 2430</b>  |  |
| 17. INFORMANT<br>ADDRESS<br><b>DOLORES HARRIS 37 N CURLEY ST.</b>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4148 CONGESTIVE HEART FAILURE</b><br>IMMEDIATE CAUSE (a)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CORONARY ISCHEMIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CORONARY ARTERY DISEASE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>7 years</b><br><b>12 years</b><br><b>15 years</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b> |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 22a. I certify that (I) (this hospital) attended the deceased from <b>1/8</b> 19 <b>83</b> , to <b>1/10</b> 19 <b>83</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/10</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.   |  | 22b. SIGNATURE<br><b>William R. Sigmund II MD</b><br>DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 22c. DATE SIGNED<br><b>1/10/83</b>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WILLIAM R. SIGMUND II</b>   |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>1-14-1983</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARDEN OF FAITHS BALTO. CO MD.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>RAYMOND L. KACZOROWSKI 2525 FLEET ST</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 12 1983</b>   |  | REGISTRAR'S SIGNATURE<br><b>Jan J. Conick</b>  |  |

MEDICAL CERTIFICATION

20% COLL



CHIEF

Handwritten notes and signatures are present across the page, including the name "W. H. H. H." and various illegible scribbles and marks.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |   |  |   |  |                          |  |   |  |
|--|--|--|--|---|--|---|--|---|--|--------------------------|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MARY   |  | MIDDLE Frances  |  | LAST Bailey   |  | PAGE  |  | 2a. DATE KNOWN OF DEATH  |  | 2b. HOUR  |  |
| 3 SEX  |  | 4 RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 24 HRS.  |  | 2c. DATE PRONOUNCED DEAD |  | 2d. HOUR  |  |
| female   |  | black  |  | 4 30 1927   |  | 55 RS.  |  | MONTHS DAYS HOURS MIN.  |  | 1 21 1983                |  | 11:35 a M   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?                             |  | 8. MARRIED  |  | NEVER MARRIED   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |                          |  |   |  |
| 35 Md  |  | U S A  |  | WIDOWED   |  | DIVORCED  |  | Baltimore City  |  |                          |  |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |  |                          |  |   |  |
| Baltimore  |  | Baltimore City Hospital                                  |  |   |  |   |  |   |  |                          |  |   |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |  |                          |  |   |  |
| Md   |  |  |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 932 N. Franklinton Rd   |  |                          |  |   |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME                                 |  |   |  |   |  |   |  |                          |  |   |  |
| John   |  | Elsie  |  |   |  |   |  |   |  |                          |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |  | 16b. SOCIAL SECURITY NO.                                 |  | 17. INFORMANT   |  | ADDRESS   |  |   |  |                          |  |   |  |
| NO   |  | 217-20-6809  |  | Eugene Bailey   |  | 5414 Relcrest Rd Apt B  |  |   |  |                          |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |  |   |  |   |  |                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |
| PART I DEATH WAS CAUSED BY:  |  |  |  |   |  |   |  |   |  |                          |  |   |  |
| 9581 IMMEDIATE CAUSE (a) Thermal injury  |  |  |  |   |  |   |  |   |  |                          |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |   |  |   |  |                          |  |   |  |
| (b)  |  |  |  |   |  |   |  |   |  |                          |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |   |  |   |  |                          |  |   |  |
| (c)  |  |  |  |   |  |   |  |   |  |                          |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |   |  |   |  |   |  |                          |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?             |  |   |  |   |  |                          |  | 20. AUTOPSY?  |  |
|  |  |  |  |   |  |   |  |   |  |                          |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                          |  |   |  |
|  |  |  |  | 9:18xx 1-20- 1983   |  |   |  | Self-immolation.  |  |                          |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION   |  |                          |  |   |  |
|  |  |  |  | home  |  |   |  | 932 N. Franklinton Rd., Balto. City Md.                                       |  |                          |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |   |  |   |  |   |  |                          |  |   |  |
| ACTUAL SIGNATURE   |  |  |  | TITLE (SPECIFY)   |  |   |  | DATE SIGNED   |  |                          |  |   |  |
| Ann M. Dixon, M.D.   |  |  |  | M.D. Assistant  |  |   |  | 1-22-83   |  |                          |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |  |  | ADDRESS   |  |   |  |   |  |                          |  |   |  |
| Ann M. Dixon, M.D.   |  |  |  | 111 Penn St., Balto., Md. 21201                               |  |   |  |   |  |                          |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY                                  |  |   |  | 23d. LOCATION            |  |   |  |
| Burial   |  |  |  | 1/26/83   |  | Mt Auburn Cem   |  |   |  | Baltimore Md             |  |   |  |
| 24. FUNERAL DIRECTOR   |  |  |  | 25a. DATE REC'D. BY REGISTRAR                                 |  |   |  | 25b. REGISTRAR'S SIGNATURE  |  |                          |  |   |  |
| William C. March F/H 1101 E. North Ave   |  |  |  | 1 JAN 24 1983   |  |   |  | John J. Connel  |  |                          |  |   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |                         |   |   |   |  |   |  |  |
|--|-------------------------|---|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Edward T. Pape, Jr.</b>  |                         |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>1 12 1983</b> |   |  | 2b. HOUR<br><b>8:15 P</b>   |  |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 6 1969</b>                         | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>13 YRS.</b>   | 7. IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.   | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>1 12 1983</b> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                       |  |  |
| 10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         | 11. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                    |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Student</b>      |  |  |
| 13a. STATE<br><b>Pennsylvania</b>  |                         | 13b. CITY OR TOWN<br><b>Southern York</b>                                     |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13d. STREET ADDRESS<br><b>Rd # 1 Box 126</b>  |  | 13e. ZIP CODE<br><b>17321</b>                |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edward T. Pape, Sr.</b>   |                         |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sandra J. Ellsworth</b>                                 |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>None</b>  |                         |   | 17. INFORMANT ADDRESS<br><b>Mr. Richard E. Haulsee same as # 13</b>   |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>9554</b> IMMEDIATE CAUSE (a) <b>Gunshot wound of head</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                         |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |                         |   |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                             |   |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR <b>4:40</b> AM MONTH DAY YEAR<br><b>1 12 1983</b> |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>subject shotself</b>  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>home</b>    |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Rt#1 Box 126, Fawngrove, Pa.</b>  |  |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                         |   |   |   |  |   |  |  |
| ACTUAL SIGNATURE<br><b>H R Guard</b>   |                         | M.D. <b>Assistant</b>   |   |   |  | DATE SIGNED <b>1/13/83</b>  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Hormez R. Guard, M.D.</b>   |                         | ADDRESS<br><b>111 Penn St., Balto, Md.</b>                                    |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                         | 23b. DATE<br><b>1/17/83</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holly Hill Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>             |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. 1050 York Road</b>   |                         |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 17 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Grier</b>                                  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO.  |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Dorothy Lee Parham</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>January</b> DAY <b>19</b> YEAR <b>1983</b>  |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>8</b> DAY <b>5</b> YEAR <b>32</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>50</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S. Carolina</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4503 Homer Avenue</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |  |
| 13e. STREET ADDRESS<br><b>4503 Homer Avenue</b>   |  | 13f. ZIP CODE<br><b>21215</b>   |  |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Clarence</b> MIDDLE <b>Horne</b> LAST <b>Horne</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Ansallina</b> MIDDLE <b>Bell</b> LAST <b>Bell</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>217-24-5006</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Emmie B. Williams 3114 Westmont Court</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Diabetes Mellitus</b><br><b>2500</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>YR</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>Oct 12</b> 19 <b>82</b> , to <b>1/19</b> 19 <b>83</b> , that (1) (we) lost<br>saw the deceased alive on <b>Oct 12</b> 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. (If (we) did not view the body after death, so state.) |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Kenneth M. Zornes MD</b>   |  |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>1/19/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Kenneth Zornes MD</b>   |  |   |  | 22e. ADDRESS<br><b>10807 Fares Rd Lutherville</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>1/22/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Auburn Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>MD</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm. C. March F/H</b> ADDRESS <b>1101 E. North Ave.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 20 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>   |  |





20% COTTON FIBRE

CHIFFON



*[Faint, illegible text and markings, possibly bleed-through from the reverse side of the page.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

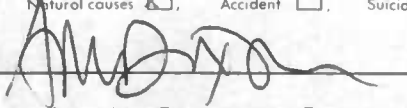

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 3 0 1 2 5 0   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |   |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>Queen (Queenie) E. Parham  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 1 10 1983  |  |   |  |
| 3. SEX<br>Female  |  | 4 RACE<br>Black   |  | 5. DATE OF BIRTH MONTH DAY YEAR 6 25 22   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Andrew Parker  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Ada Taylor  |  | 13e. STREET ADDRESS<br>1647 Normal Avenue 21213   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>219-20-8724   |  | 17. INFORMANT ADDRESS<br>Mary Dorothy Johnson 1647 Normal Ave.  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) SHOCK<br>5860<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b)<br>Renal failure, GI bleeding  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/6 1982 to 1/10 1983, that (I) (we) lost saw the deceased alive on 1/10/83 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.                                |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>Robert S. Tano M.D.   |  |   |  | DEGREE<br>M.D.  |  | 22c. DATE SIGNED<br>1/10/83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ROBERT TANO, M.D.  |  |   |  | 22e. ADDRESS<br>UNION MEMORIAL HOSPITAL   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>1/14/83  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Calvary Cem.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Anne Arundel Co. MD  |  |
| 24. FUNERAL DIRECTOR<br>Wm. C. March F/H 1101 E. North Ave.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 11 1983  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Connel  |  |



Items #10a-22a Film G577 3/9/83 reSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |  |                         |  |   |  |  |  |   |  |   |  |   |  |  |  |
|--|--|-------------------------|--|---|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LATASHA L. PARKS</b>  |  |                         |  |   |  |  |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1 27 19 83</b> |  |   |  | 2b. HOUR<br><b>M</b>   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>9 19 81</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>1 YRS.</b>                     |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>1 27 19 83</b>  |  | 2d. HOUR<br><b>10:15 a M</b>  |  |  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Johns Hopkins Hospital</b> |  |  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>  |  |                         |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                |  | 13d. INSIDE CITY LIMITS?<br><b>YES</b> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>915 N. Kenwood Avenue 21205</b>   |  |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Melvin Parks</b>  |  |                         |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Gracie Jones</b> |  |   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |  |                         |  | (IF YES, GIVE WAR OR DATES)   |  | 16b. SOCIAL SECURITY NO.<br><b>217-98-9932</b>                       |  | 17. INFORMANT ADDRESS<br><b>Elsie Pittman 915 N. Kenwood Avenue</b>   |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY: <b>Sudden Infant Death Syndrome</b><br><b>7981</b><br>IMMEDIATE CAUSE (a) <b>7981</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH        |  |                         |  |   |  |  |  |   |  |   |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                         |  |   |  |  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |  |   |  |  |  |   |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br>  |  |                         |  |   |  | TITLE (SPECIFY)<br>M.D. <b>Assistant</b> MEDICAL EXAMINER            |  |   |  |   |  | DATE SIGNED<br><b>1-28-83</b>   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Ann M. Dixon, M.D.</b>   |  |                         |  |   |  | ADDRESS<br><b>111 Penn St., Balto., Md. 21201</b>                    |  |   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |                         |  | 23b. DATE<br><b>1/31/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Eastview Memorial pk</b>    |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co, Md.</b>                                    |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H Inc.</b>   |  |                         |  |   |  | ADDRESS<br><b>1101 E. North Avenue</b>                               |  |   |  | 25a. DATE RECEIVED BY REGISTRAR<br><b>JAN 31 1983</b>   |  |   |  | REGISTRAR'S SIGNATURE<br> |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



15000



Jan 21 1903  
J. H. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or a coroner's inquest must be held.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |   |  |  |   | REG. NO.<br>8301252                             |  |
|--|--|---|--|---|---|---|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Agnes Wright PAYNE</b>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01 27 83</b>              |   |  | 2b. HOUR<br>MIN<br><b>602 AM</b>   |   |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 16 18</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |   |  |
| 7a. BIRTH PLACE<br>(COUNTRY)<br><b>Baltimore</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hosp of Baltimore</b> |  |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>for m.a.s. Dept Store</b> |  |   | 12b. KIND OF BUSINESS OR INDUSTRY               |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>Balt</b>  |  | 13c. CITY OR TOWN<br><b>Balt</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3306 SUMTER AVENUE</b>   |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>W. H. A. M. WRIGHT</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Violet LEVY</b> |   |  |  |   | 21215   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>220-01-6373</b>  |  | 17. INFORMANT<br><b>Robert W. Payne</b>   |   |   |  |  | ADDRESS<br><b>3306 SUMTER AVE</b>         |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br><b>4414</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>dissecting abdominal aortic aneurysm</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                    |  |   |  |   |   |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>(2) CVA</b>   |  |   |  |   |   |   |  |  |   |   |  |
| 19a. DATE OF OPERATION<br><b>1/27/83</b>   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>CVA</b> |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>12 17 83</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |   |  |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |   |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>12/17/82</b> to <b>1/27/83</b> , that (1) (this hospital) saw the deceased alive on <b>1/27/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I/we) (did) (did not) view the body after death. |  |   |  |   |   |   |  |  |   |   |  |
| 22b. SIGNATURE<br><b>Neal Kurzrok MD</b>   |  |   |  |   | DEGREE<br><b>MD</b>   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1/27/83</b>              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>NEAL KURZROK MD</b>  |  |   |  |   | 22e. ADDRESS<br><b>Sinai Hosp of Baltimore</b>                      |   |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OF)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>1/31/83</b>                                    |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt Auburn</b>              |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, MD</b>   |   |   |  |
| 24. FUNERAL DIRECTOR<br><b>Marshall A. Hays</b>  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 28 1983</b>                 |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>  |   |   |  |

BP

10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be detached for use as the burial transit permit. Then please reissue carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18, show any injury, or other traumatic event, the medical examiner must make a note to that effect.

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| Item #5 Film G575 1/26/83 rc  |  | STATE OF MARYLAND  |  | 8 3 0 1 2 5 3   |  |
| 1. FOR item 23d #G584 10/25/83  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  | ph  |  |
| 1. STATE REGISTRAR  |  | ph   |  | REG. NO.  |  |
| 1 DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | 2a DATE OF DEATH MONTH DAY YEAR   |  |
| GERTRUDE  |  | PAYNE  |  | 1 10 83   |  |
| 3 SEX   |  | 4 RACE   |  | 5. DATE OF BIRTH MONTH DAY YEAR   |  |
| Female  |  | Black  |  | 9 21 1895   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b CITIZEN OF WHAT COUNTRY?  |  | 6 AGE (IN YEARS LAST BIRTHDAY)  |  |
| Kentucky  |  | USA  |  | 85 87 YRS   |  |
| 11. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| BALTIMORE   |  | Provident Hospital   |  | BALTIMORE MD  |  |
| 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| Domestic  |  | Pvt. Family  |  |   |  |
| 13a STATE   |  | 13b COUNTY   |  | 13c CITY OR TOWN  |  |
| Maryland  |  |  |  | Baltimore   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| Nathaniel Griffith  |  | Elizabeth Richardson   |  | 13e STREET ADDRESS  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)   |  | 17 INFORMANT ADDRESS  |  |
| NO  |  | 401-42-3631A   |  | 5 Cinnamon Circle, Apt 2B, Randallstown, MD   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4292  |  | DUE TO, OR AS A CONSEQUENCE OF (b) CVA   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  | DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |
| 19a DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)              |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)                                     |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-10-19-83, to 1-10-19-83, that (I) (we) last saw the deceased alive on 1-10-19-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED  |  |
| RGA ISOLAND   |  | MD   |  | 1-10-83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e ADDRESS  |  |   |  |
| RGA ISOLAND   |  |  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| Burial  |  | 1/15/83  |  | Elmwood Cemetery  |  |
| 24 FUNERAL DIRECTOR NAME  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |
| HERBERT E. NUTTER 3035 W. NORTH AVE   |  | JAN 13 1983  |  | John J. Connelley   |  |
| 23d. LOCATION CITY OR TOWN  |  | 23e. COUNTY  |  | 23f. STATE  |  |
| Owensboro   |  | Queensboro, KY   |  |   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, LEAVE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                |   |  |   |  |   |  |   |  | REG. NO. 01254 |  |
|--|----------------|---|--|---|--|---|--|---|--|----------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>Joseph Pearson   |                |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>1 15 19 83 |  | 2b. HOUR<br>M<br>2:30A  |  |                |  |
| 3. SEX<br>male   | 4. RACE<br>Col | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 - 19 - 53  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>29 YRS. | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN  | 8. IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>1 15 19 83  |  | 2d. HOUR<br>M   |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BALTO. Md.  |                | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.   |  |   |  |                |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Lutheran Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK OR INDUSTRY)<br>HANDYMAN Self-employed                            |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                |  |
| 13a. STATE<br>Maryland   |                | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |  | 13e. STREET ADDRESS<br>615 Brice St 12123   |  |                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Richard O. Pearson   |                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>DAISY HARVIN   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>247-02-6664   |  | 17. INFORMANT<br>ADDRESS<br>MRS. DAISY PEARSON 3015 W. Lankford St                  |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple stab wounds<br>9660<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF  |                |   |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |                |   |  |   |  |   |  |   |  |                |  |
| 19a. DATE OF OPERATION   |                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                | 21b. TIME OF INJURY<br>HOUR XX MONTH DAY YEAR<br>11:55 P.M. 1 14 19 83  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br>Subject stabbed  |  |   |  |   |  |                |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>street   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>In front of 2019 Edmondson Ave, Balto. City, Md.   |  |   |  |   |  |                |  |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> , inspection <input type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                |   |  |   |  |   |  |   |  |                |  |
| ACTUAL SIGNATURE<br>Thomas D. Smith, M.D.  |                | TITLE (SPECIFY)<br>Deputy Chief, MEDICAL EXAMINER   |  |   |  |   |  | DATE SIGNED<br>1/15/83  |  |                |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Thomas D. Smith, M.D.   |                | ADDRESS<br>111 Penn St. Balto., MD.   |  |   |  |   |  |   |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |                | 23b. DATE<br>1-21-83  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Zion Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Lansdowne Md.   |  |   |  |                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Joseph L. Russ   |                | ADDRESS<br>2222 W. North Ave  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 21 1983  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Canine  |  |   |  |                |  |



*[Faint, mostly illegible handwritten text on lined paper. The text appears to be a memorandum or report, possibly containing dates and names, but is too faded to transcribe accurately.]*



2025 RELEASE UNDER E.O. 14176

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation or entombment.

IMPORTANT: If item 21 is marked as fatal, it is a reportable injury, or other traumatic event, the Medical Examiner must be notified of this.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WILLIAM JAMES PEET</b>                                   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>01/11/83</b>                                       |  | 2b. HOUR<br><b>8:30a</b>                              |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>DEC. 6, 1937</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>45</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.        |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                         |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>COMMUNICATIONS</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. GOVT</b> |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b> |  |   | 13b. COUNTY<br><b>MONTGOMERY</b>  |  |   |
| 13c. CITY OR TOWN<br><b>GAITHERSBURG</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 13e. STREET ADDRESS<br><b>411 WESTSIDE DR. 20878</b>                   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CHARLES CODD PEET</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>HELEN MAZONEK</b>   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>                                      |  | 16b. SOCIAL SECURITY NO.<br><b>WW 2 214-34-3207</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>EILEEN E. PEET 411 WESTSIDE DR. MD.</b> |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

1629

IMMEDIATE CAUSE (a)

*Cardiopulmonary arrest*

DUE TO, OR AS A CONSEQUENCE OF

(b)

*Metastatic lung carcinoma 10 mos*

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

*Metastatic small intestine carcinoma*

19a. DATE OF OPERATION

12/17/83

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

*Carcinoma*

20a. AUTOPSY?

YES ☒ NO ☐20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/30, 19 82, to 1/11/83, 19 83, that (I) (we) last saw the deceased alive on 1/11, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

*F. J. Colli*

DEGREE

ATTENDING  
PHYSICIAN ☐MEDICAL  
DIRECTOR ☐STAFF  
PHYSICIAN ☒

22c. DATE SIGNED

1/11/83

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

*F. Colli*

22e. ADDRESS

*Johns Hopkins Hospital*23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)  
**CREMATION**

23b. DATE

**JAN. 13, 1982**

23c. NAME OF CEMETERY OR CREMATORY

**GREEN MOUNT CEM.**23d. LOCATION  
CITY OR TOWN**BALTIMORE**

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

ADDRESS

**MITCHELL-WIEDEFELD HOME 6500 YORK RD. 21212**

25a. DATE REC'D BY REGISTRAR

**JAN 18 1983**

25b. REGISTRAR'S SIGNATURE

*John J. [Signature]*

8:30 PM

1951

NOV 6, 1951

MEMPHIS CITY

THE JERRY HOPKINS HOSPITAL

MEMPHIS

DOCTOR J. H. HOPKINS

200

2

NOV 6, 1951

Dr. J. H. Hopkins

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (1))  
20M 4/82

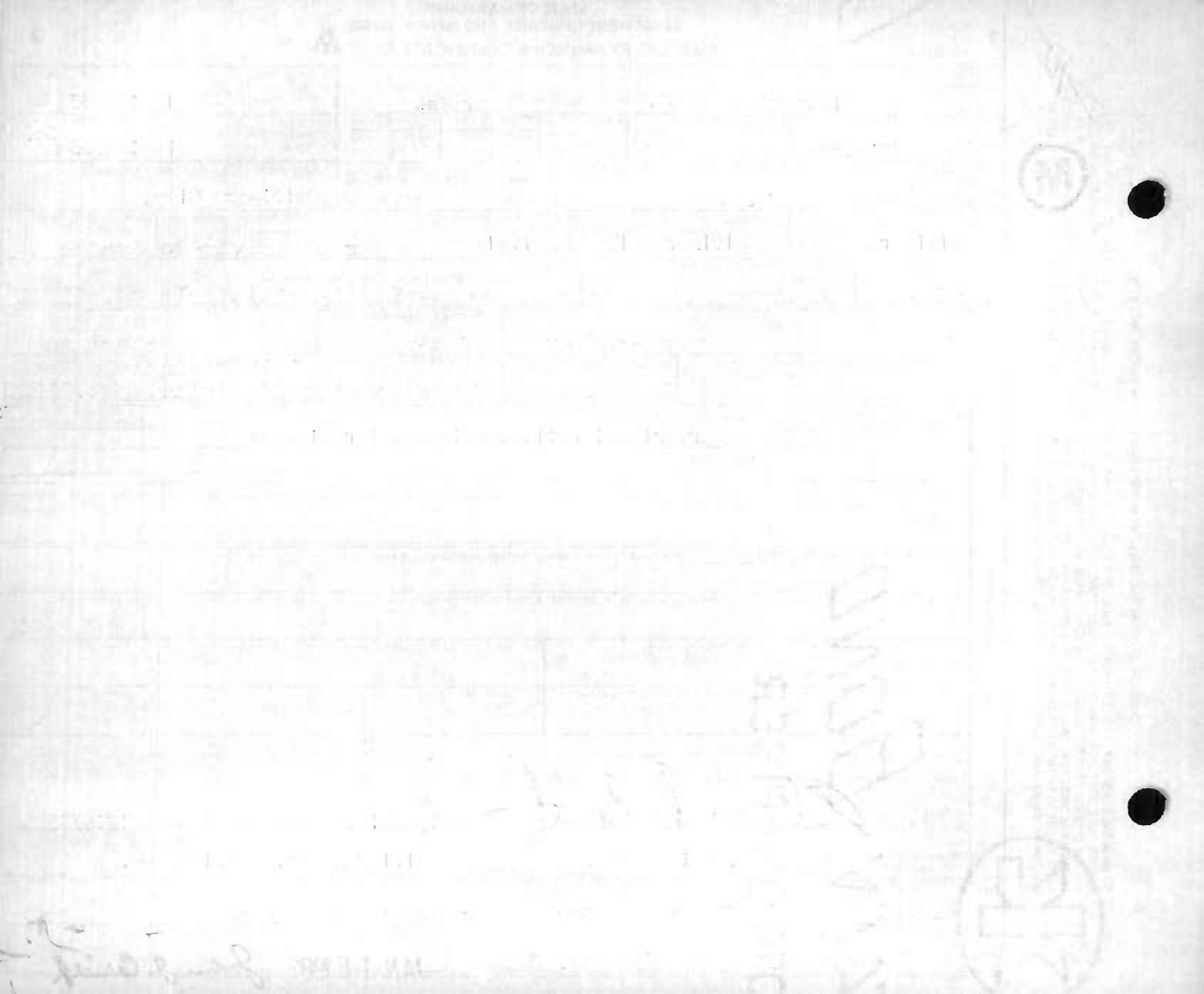
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |                          |  |  |  |  |  |                        |  |  |  |  |  |  |
|--|--|--|---|--|--|---|--|--|---|--|--|---|--|--|---|--|--|---|--|--|--------------------------|--|--|--|--|--|------------------------|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST<br>Vincent  |  |  | MIDDLE<br>J.  |  |  | LAST<br>Pekarofsky  |  |  | 2a. DATE KNOWN<br>OF DEATH  |  |  | ESTI-<br>MATED  |  |  | MONTH<br>1  |  |  | DAY<br>16                |  |  | YEAR<br>1983                                 |  |  | 2b. HOUR<br>M<br>3:30A |  |  |  |  |  |  |
| 3. SEX<br>Male   |  |  | 4. RACE<br>White  |  |  | 5. DATE OF BIRTH<br>MONTH<br>5  |  |  | DAY<br>4  |  |  | YEAR<br>30  |  |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>52 YRS.           |  |  | IF UNDER 1 YR.<br>MONTHS  |  |  | IF UNDER 24 HRS.<br>DAYS |  |  | HOURS  |  |  | MIN.                   |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>Pennsylvania   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  | 8. MARRIED<br>WIDOWED   |  |  | NEVER MARRIED   |  |  | DIVORCED  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, |  |  | MD  |  |  |                          |  |  |  |  |  |                        |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospital |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br>Truck Driver-Bo |  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY<br>Brooks  |  |  |   |  |  |   |  |  |   |  |  |                          |  |  |  |  |  |                        |  |  |  |  |  |  |
| 13a. STATE<br>Maryland   |  |  | 13b. CITY OR TOWN<br>Baltimore  |  |  | 13c. CITY OR TOWN<br>Dundalk  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET ADDRESS<br>2619 Plainfield Rd. 21222                              |  |  |   |  |  |   |  |  |                          |  |  |  |  |  |                        |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST<br>John   |  |  | MIDDLE  |  |  | LAST<br>Pekarofsky  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>Susan  |  |  | MIDDLE<br>Kasprisan   |  |  | LAST<br>2619 Plainfield Road                            |  |  |   |  |  |                          |  |  |  |  |  |                        |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |  | (IF YES, GIVE WAR OR DATES)   |  |  | 16b. SOCIAL SECURITY NO.<br>164-22-3426   |  |  | 17. INFORMANT<br>Veronica Kincaid Balto., MD. 21222   |  |  |   |  |  |   |  |  |   |  |  |                          |  |  |  |  |  |                        |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause, last.   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |                          |  |  |  |  |  |                        |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |                          |  |  |  |  |  |                        |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                   |  |  |   |  |  |   |  |  |   |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |                          |  |  |  |  |  |                        |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                          |  |  |   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |   |  |  |   |  |  |                          |  |  |  |  |  |                        |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |   |  |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)                      |  |  |   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |  |   |  |  |   |  |  |                          |  |  |  |  |  |                        |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |  |   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |                          |  |  |  |  |  |                        |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br>Thomas D. Smith, M.D.  |  |  |   |  |  | TITLE (SPECIFY)<br>M.D. Deputy Chief  |  |  |   |  |  |   |  |  |   |  |  | DATE SIGNED<br>1/16/83  |  |  |                          |  |  |  |  |  |                        |  |  |  |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  |  |   |  |  | ADDRESS<br>111 Penn St. Balto, MD.  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |                          |  |  |  |  |  |                        |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  |   |  |  | 23b. DATE<br>1/20/1983  |  |  |   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Joseph Cemetery                     |  |  |   |  |  | 23d. LOCATION<br>CITY OR TOWN<br>Nanitcoke  |  |  |                          |  |  | COUNTY<br>Pa.                                |  |  |                        |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Duda-Ruck, Inc.  |  |  |   |  |  |   |  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 18 1983                                  |  |  |   |  |  |   |  |  |                          |  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Casier |  |  |                        |  |  |  |  |  |  |
| 7922 Wise Avenue Dundalk, MD. 21222  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |                          |  |  |  |  |  |                        |  |  |  |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 3 0 1 2 5 7   |  |  |  |
|---|--|---|--|---|--|--|--|
| FOR<br>STATE<br>REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JACOB W. PELTZ</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JANUARY 4 1983</b>   |  | 2b. HOUR<br><b>2:10P. M</b>  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>JULY 15, 1896</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PLEASANT MANOR NURSING HOME</b>                              |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PAINTER</b>  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>DECORATION</b>  |  | 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  |
| 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>2500W. BELVEDERE AVE. APT. 527</b>  |  | 13f. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13g. STATE<br><b>MARYLAND</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>KENNETH PELTZ</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>ANNA FLITT</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>577-10-1253</b>   |  |
| 16c. ADDRESS<br><b>MRS. TILLIE J. FELDMAN 6503 STEERFORTH CT.</b>   |  | 16d. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 16e. STATE<br><b>MARYLAND</b>   |  | 16f. ZIP CODE<br><b>21209</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe Arterio sclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>4409</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hr</b><br><b>12 mos.</b>   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-4</b> , 19 <b>82</b> , to <b>1-4</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>1-4</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                             |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Jaime Punzalan</b>   |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input checked="" type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/5/83</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAIME PUNZALAN</b>  |  | 22e. ADDRESS<br><b>5214 Harford. Balto. Md.</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>1/6/83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WORKMEN CIRCLE CEM</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 12 1983</b>   |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John J. [Signature]</b>  |  |   |  | 25c. REGISTRAR'S NAME<br><b>JOHN J. [Signature]</b>   |  |  |  |
| 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215   |  |   |  |   |  |  |  |

BP



THIRTY

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 2 5 8

FOR  
1- STATE  
REGISTRAR

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>FRANCES J. PENCE</b>                 |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>1/5/83</b> |  |  | 2b. HOUR <b>6:29pm</b>   |  |
| 3. SEX <b>F</b>   |  | 4. RACE <b>W</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>10 02 1909</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>                   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IS NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>John Deaton Medical Center</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NURSE'S AIDE</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>NURSING</b>   |  |
| 13a. STATE <b>MARYLAND</b>  |  | 13b. COUNTY <b>HOWARD</b>  |  | 13c. CITY OR TOWN <b>ELKRIDGE</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>MELVIN JONES</b>                     |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY RAYE</b>  |  | 13e. STREET ADDRESS <b>6410 FORREST AVENUE, 21227</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b> |  | 16b. SOCIAL SECURITY NO. <b>344-16-4063</b>  |  | 17. INFORMANT ADDRESS <b>DORIS R. FARMER 6410 FORREST AVENUE, 21227</b>  |  |  |  |

|   |  |   |  |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4280</b> IMMEDIATE CAUSE (a) <b>Cardio-Pulmonary Arrest</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  | (b) <b>Chronic obstructive Pulmonary Disease</b> <b>Years</b> |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Coronary Heart Failure</b> <b>Years.</b>   |  |   |  |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)

**Sacral docubiti / Organic Brain Syndrome**

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |

22a. I certify that (I) (this hospital) attended the deceased from **11/29**, 19 **82**, to **1/5**, 19 **83**, that (I) ☒ saw the deceased alive on above (I) ☒ saw the body after death, and that in my (our) opinion death occurred on the date and hour and from the causes stated.

|  |  |   |  |   |  |                                |  |
|--|--|---|--|---|--|--------------------------------|--|
| 22b. SIGNATURE <b>David W. McClure MD</b>                        |  | DEGREE <b>MD</b>                                      |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED <b>1/6/83</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>David W. McClure MD</b> |  | 22e. ADDRESS <b>611 S. Charles St. Balt. Md 21206</b> |  |   |  |                                |  |

|   |  |                                  |  |   |  |  |  |
|---|--|----------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>  |  | 23b. DATE <b>01-07-83</b>        |  | 23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b> |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b> |  |
| 24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b> |  | ADDRESS <b>4107 WILKENS AVE.</b> |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 7 - 1983</b>     |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>                       |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 2 5 9

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |  |   |                            |  |  |
|--|--|---|--|---|----------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>FIRST MIDDLE LAST</b><br><b>Sydney ASHAY Pendleton</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Jan 2, 1983</b> |   | 2b. HOUR<br><b>6:25 AM</b> |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>May 19 10</b>   |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Florida</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UMH</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>XXXXXX XXXXXX Real Estate Broker</b>   |                            | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Frederick</b>   |  | 13c. CITY OR TOWN INSIDE CITY LIMITS?<br><b>BALDWIN HEIGHTS</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                            | 13d. STREET ADDRESS<br><b>5630 Jefferson Blvd</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HAROLD A. PENDLETON</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>BLANCHE RUST</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b>   |                            | 16b. SOCIAL SECURITY NO.<br><b>W.W.11 020-12-7927</b>  |  |
| 17. INFORMANT<br><b>Mr. Richard A. Pendleton</b>   |  | ADDRESS<br><b>5630 Jefferson Blvd Frederick, Md. 21701</b>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>peritonitis?</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Intestinal obstruction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)   |  |   |  |   |                            |  |  |
| 19a. DATE OF OPERATION<br><b>Dec 31, 82</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Poa</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |                            |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 2, 1983</b> to <b>Jan 2, 1983</b> , that (I) (we) lost saw the deceased alive on <b>Jan 2, 1983</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |                            |  |  |
| 22b. SIGNATURE<br><b>B. S. Shin, M.D.</b>  |  | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |                            | 22c. DATE SIGNED<br><b>Jan 2 '83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Baekhyo Shin</b>   |  | 22e. ADDRESS<br><b>U.M.H. Baltimore</b>   |  |   |                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>Jan/4/1983</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Smithsburg Crematory</b>   |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Smithsburg, Wash. Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Robert E. Dailey &amp; Son, P.A.</b>  |  | ADDRESS<br><b>Frederick, Md. 21701</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 10 1983</b>   |                            | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Grieb</b>   |  |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 of 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 19 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 2 6 0

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |   |   |  |   |  |
|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JOHN L. PENSMITH</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-14-83</b>                              |   | 2b. HOUR<br><b>145 P M</b>   |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 24, 1942</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>40</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                    |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington D.C.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University of Maryland Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Printer</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Printing Co.</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md. 20737</b>   |   |   | 13b. CITY OR TOWN<br><b>Prince Geo. Riverdale</b>                                  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Lewis Pensmith</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Winifred Gough</b>             |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>577 54 0885</b>  | 17. INFORMANT<br>ADDRESS<br><b>Alice F. Pensmith Same as #13 (Wife)</b>            |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>2169 IMMEDIATE CAUSE (a) respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>fibrous histiocytoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>brain and subarachnoid history of Hodgkins disease</b>   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 19c. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>DEC 26, 1982</b> to <b>JAN 14, 1983</b> , that (I) (we) lost saw the deceased alive on <b>JAN 14, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                     |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Michael Hamilton MD</b>  |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>1/14/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J MICHAEL HAMILTON MD</b>   |   | 22e. ADDRESS<br><b>UNIV. OF MD HOSP. BALT MD 21201</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>  |   | 23b. DATE<br><b>1/17/83</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>                  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood P.G. Maryland</b> |
| 24. FUNERAL DIRECTOR<br><b>Francis Gasch's Sons Funeral Home, P.A.</b><br>ADDRESS<br><b>Hyattsville, Maryland</b>   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 19 1983</b>                                |   |  |

25b. REGISTRAR'S SIGNATURE



100. 24. 1912

100. 24. 1912



Handwritten text at the bottom of the page, including names and dates, mostly illegible due to fading and bleed-through.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 2 6 1

REG. NO.

|  |  |   |   |   |  |  |  |
|--|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Allen H. Perkov   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 19, 1983 |   |  | 2b. HOUR<br>12:45aM  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 1, 1919  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Washington, D.C.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinai Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Marine Engineer   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Unknown  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Unknown  |   | 13e. STREET ADDRESS<br>341 Bigley Avenue 21227  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>----- 213-16-5509  |   | 17. INFORMANT'S NAME AND ADDRESS<br>Mr. John Perkov<br>341 Bigley Avenue Baltimore, Maryland 21227  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>4100 IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic heart disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 day<br>4 years   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)<br><u>None</u>  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21i. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (the <u>hospital</u> ) attended the deceased from <u>June 3, 1980</u> , to <u>Jan 19, 1983</u> , that (I) ( <u>we</u> ) lost <u>saw the deceased alive on Jan 17, 1983</u> , and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <u>we</u> ) ( <u>did not</u> ) view the body after death.                 |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><u>Manuel Levin</u>  |  | DEGREE<br><u>M.D.</u>   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><u>1/19/83</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Manuel Levin  |  | 22e. ADDRESS<br>6101 Park Heights Ave.  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>1-21-83  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Lake View Mem. Park   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Sykesville, Carroll Maryland   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Loring Byers Funeral Directors, Inc.<br>8728 Liberty Rd. Randallstown, Md. 21133   |  |   |   | 25. DATE<br>JAN 20 1983   |  |  |  |
| 26. REGISTRAR'S SIGNATURE<br><u>John J. Loring</u>   |  |   |   | 27. REGISTRAR'S SIGNATURE   |  |  |  |

MEDICAL CERTIFICATION

11

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 2 6 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |  |   |  |   |   |  |                 |      |  |
|---|---|--|---|--|---|---|--|-----------------|------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   | FIRST  | MIDDLE  | LAST   | 2a. DATE OF DEATH   |   | MONTH  | DAY             | YEAR | 2b. HOUR                                     |
| JOHN E. PETERS  |   |  |   |  | 01-26-83  |   |  |                 |      | 6:05pm                                       |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH   |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS |      |  |
| Male  | White   | MONTH DAY YEAR<br>2 7 1901   |   | 81 YRS.  |   | MONTHS DAYS   |  | HOURS MIN.      |      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |   |  |                 |      |  |
| DC  | U.S.A.  |  |   | Baltimore City MD  |   |   |  |                 |      |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |   |  |                 |      |  |
| Baltimore City  | Church Home Hospital  |  | Ret. Clerk-Balt.  |  | Gas & Electric Co.  |   |  |                 |      |  |
| 13a. STATE  | 13b. COUNTY   | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS  |   |   |  |                 |      |  |
| MD  | Baltimore   | Pikesville   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 715 Leafydale Terrace 21208  |   |   |  |                 |      |  |
| 14. FATHER'S NAME   |   | 15. MOTHER'S MAIDEN NAME   |   |  |   |   |  |                 |      |  |
| FIRST MIDDLE LAST<br>Joseph J. Peters   |   | FIRST MIDDLE LAST<br>Minnie A. Norris  |   |  |   |   |  |                 |      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS  |   |   |  |                 |      |  |
| Yes   |   | WW I 219-10-7490   |   | Mr. Jay E. Peters<br>715 Leafydale Terrace, Pikesville, MD 21208               |   |   |  |                 |      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>1490 IMMEDIATE CAUSE (a) <u>CANCER OF THE PHARYNX WITH METASTASIS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |   |  |   |  |   |   |  |                 |      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |   |  |   |  |   |   |  |                 |      |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                 |      |  |
|   |   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                 |      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |  |                 |      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |  |                 |      |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 1-10-83, to 1-26-83, that (1) (we) lost<br>saw the deceased alive on 1-26-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (1) (we) (did) (did not) view the body after death.  |   | 22b. SIGNATURE<br><i>[Signature]</i>   |   | 22c. DATE SIGNED<br>1-26-83  |   | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. A.F. NOUR M.D. |  |                 |      |  |
| 22e. ADDRESS  |   | 22f. ADDRESS<br>100 N. BROADWAY BALTIMORE, MARYLAND 21231  |   |  |   |   |  |                 |      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |   | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                  |  |                 |      |  |
| Burial  |   | 1/29/83  |   | Lorraine Park  |   | Woodlawn Baltimore MD                                       |  |                 |      |  |
| 24. FUNERAL DIRECTOR Loring Byers Funeral Directors, Inc.<br>8728 Liberty Rd., Randallstown, MD 21133   |   |  |   | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE                                  |  |                 |      |  |
|   |   |  |   | JAN 28 1983  |   | <i>[Signature]</i>  |  |                 |      |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

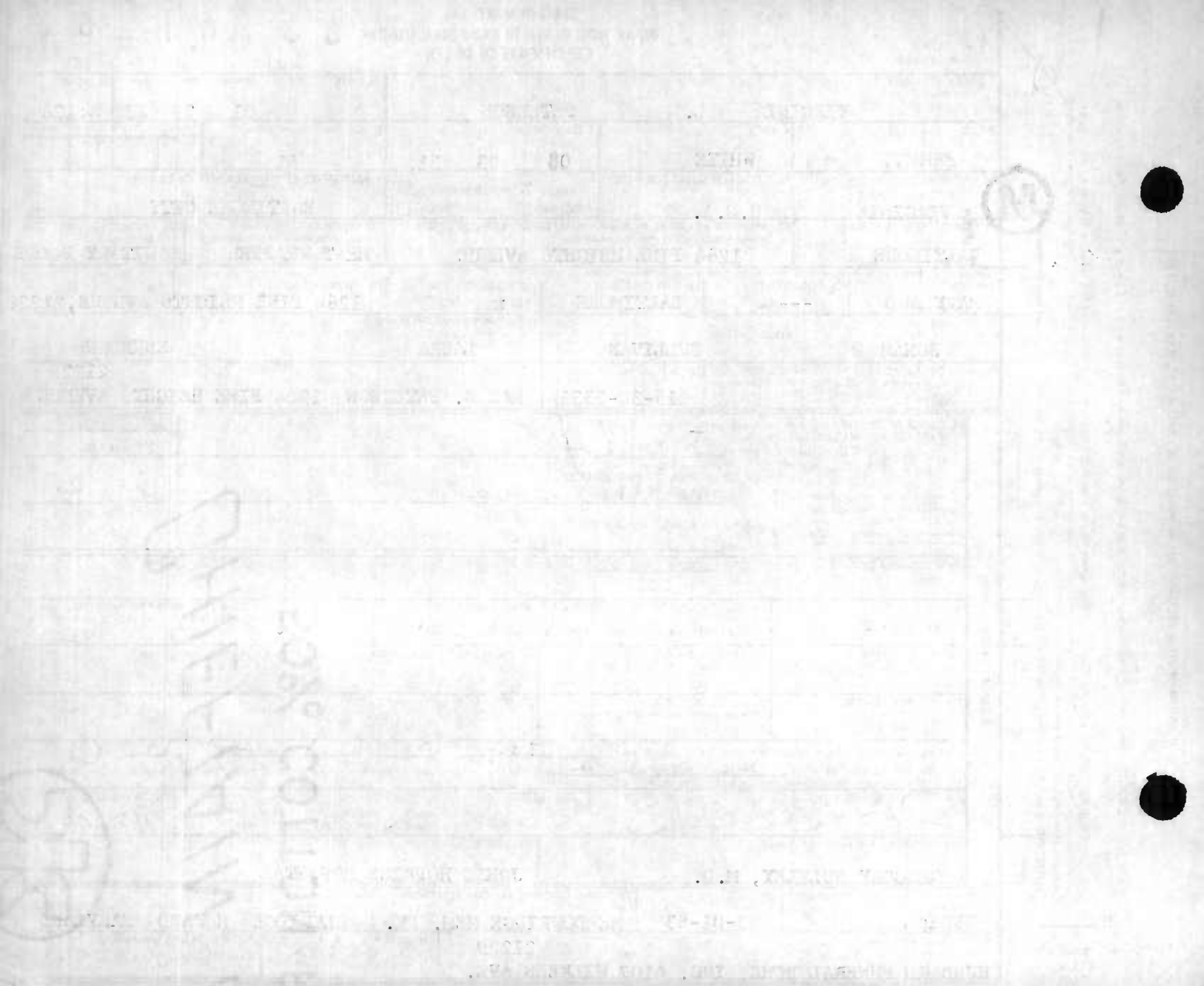
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the Registrar with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 3 0 1 2 6 3   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>VIRGINIA L. PETERSON  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>01 29 83   |  | 2b. HOUR<br>4:12A M  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>08 23 31  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>51 YRS.   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VIRGINIA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1264 PINE HEIGHTS AVENUE |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MEAT WRAPPER  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>SANITARY FOODS  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND  |  |   |  | 13b. COUNTY<br>---  |  | 13c. CITY OR TOWN<br>BALTIMORE   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JONAH SULLIVAN  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LAURA UNKNOWN  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-30-3331  |  | 17. INFORMANT<br>ADDRESS<br>MAX G. PETERSON 1204 PINE HEIGHTS AVENUE 21229  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Innate</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Metastatic Carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 week</u><br><u>6 months</u> |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>11/5/82   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Gastrostomy for inability to swallow  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>81</u> , to <u>Nov 10 (approx)</u> , 19 <u>83</u> , that (I) (we) lost<br>saw the deceased alive on <u>Nov. 10 (approx) 19 82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>[Signature]</u>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>1/29/83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GREGORY BULKLEY, M.D.  |  |   |  | 22e. ADDRESS<br>JOHNS HOPKINS HOSPITAL  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>02-01-83   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MEADOWRIDGE MEM. PK.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>ELKRIDGE HOWARD MARYLAND   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 31 1983  |  |  |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1-4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 1B shows any injury, or other traumatic event, the medical examiner will be notified.

BP

DHMH-16 50M 1/81  
(VRA 15, 4)

| FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8301264<br>REG. NO.   |  |   |  |
|--|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH   |  |  |  | 2b. HOUR  |  |   |  |
| Alisha Peyton  |  |  |  | 1 26 83   |  |  |  | M   |  |   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR   |  | IF UNDER 74 HRS   |  |
| Female   |  | Black  |  | 7 4 02  |  | 80 YRS   |  | MONTHS DAYS   |  | HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |   |  |
| Virginia   |  | U.S.A.   |  |   |  | Baltimore City, MD.  |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |  |
| Baltimore  |  | 11 West 20th St. Apt. 11G  |  |   |  |  |  |   |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  | 13a. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS   |  |   |  |
| 13a. STATE   |  |  |  | 13b. COUNTY   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 11 W. 20th St. Apt. 11G 21218                                       |  |   |  |
| Maryland   |  |  |  | Baltimore   |  |  |  |   |  |   |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |   |  |   |  |
| George Taylor  |  |  |  | N/A   |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |  |   |  |   |  |
| No   |  |  |  | 220-30-5681   |  | Frederick Peyton 11 W. 20th St. Apt. 11G                                       |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.  |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |
| 4151 IMMEDIATE CAUSE (a) Respiratory failure   |  |  |  |   |  |  |  |   |  | 2 mos   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Thrombophlebitis  |  |  |  |   |  |  |  |   |  | 2 mos   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary embolus, chronic brain syndrome   |  |  |  |   |  |  |  |   |  | 2 mos   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: c cardiac arrhythmia  |  |  |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|  |  |  |  |   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) |  |   |  |   |  |
|  |  |  |  | HOUR A.M. MONTH DAY YEAR  |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION  |  |   |  |   |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  |  |   |  | CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 9, 1982 to January 7, 1983, that (I) (we) last saw the deceased alive on 1-7-83, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE   |  |  |  | DEGREE  |  |  |  | 22c. DATE SIGNED  |  |   |  |
| Joseph R. Myerowitz MD   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |  |  | 1-28-83   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS  |  |  |  |   |  |   |  |
| Joseph R. MYEROWITZ MD   |  |  |  | 6615 Reisterstown Rd  |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL  |  |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |   |  |
| BURIAL   |  |  |  | 1/31/83   |  | Arbutus Mem. Pk.,  |  | Arbutus COUNTY STATE  |  |   |  |
| 24. FUNERAL DIRECTOR   |  |  |  |   |  | 25a. DATE OF DEATH   |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |
| Wm. C. March F/H Inc. 1101 E. North Avenue   |  |  |  |   |  | JAN 28 1983  |  | John J. Conish  |  |   |  |



JAN 28 1953  
J. W. G. G. G.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 2 6 5

REG. NO.

|   |  |  |  |   |                            |   |  |  |  |  |  |
|---|--|--|--|---|----------------------------|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>FIRST JULIUS MIDDLE PFEIFFER LAST</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>FRIDAY, JAN. 14, 1983</b> |   | 2b. HOUR<br><b>1:36 PM</b> |   |  |  |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>FEB. 17, 1901</b>   |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>GERMANY</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |  |   |                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SALESMAN</b>             |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>TEXTILES</b> |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |                            |   |  |  |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2604 WILLOW GLEN DR. (21209)</b>                           |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOSEF PFEIFFER</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>KLARA KUNSTLER</b>  |                            |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>130-05-01544</b>   |                            | 17. INFORMANT<br>ADDRESS<br><b>MRS. EDITH LAMM 2604 WILLOW GLEN DR. (21209)</b>                 |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4960 Ac. Respiratory Insufficiency</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>COPD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Pulm. Hc</b>                       |  |  |  |   |                            |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 hrs.</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (UNLESS RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1):<br><b>Pneumonia Vulgaris</b>  |  |  |  |   |                            |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                            |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7-16-83</b> , 19 <b>83</b> , to <b>1-14-83</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1-4-83</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) did not view the body after death. |  |  |  |   |                            |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Daniel Bakal</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                            |   |  | 22c. DATE SIGNED<br><b>1/14/83</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DANIEL BAKAL</b>  |  |  |  | 22e. ADDRESS<br><b>600 REISTERSTOWN RD. BALTIMORE, MD. (21208)</b>  |                            |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL /REMOVAL</b>   |  |  |  | 23b. DATE<br><b>1/16/83</b>   |                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR PARK BETH EL</b>                                 |  |  | 23d. LOCATION<br><b>WESTWOOD, N.J.</b> COUNTY STATE  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SOL LEVINSON &amp; BROS.<br/>6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)</b>  |  |  |  |   |                            | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 18 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                     |  |  |  |

BP



CHIEF  
20X 0011

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 83 01266   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>ROBERT B. PICK  |  |   |  | 2b. HOUR 1235 am  |  |   |  |
| 3. SEX MALE   |  | 4. RACE WHITE   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>FEB. 27, 1901  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>AUSTRIA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO. CITY  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE UNION MEMORIAL HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>BROKER   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>GRAIN  |  |
| 13a. STATE MD.  |  |   |  | 13b. COUNTY   |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>LUDWIG PICK  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>BERTHA WEISS  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>056-03-6830A  |  | 17. INFORMANT ADDRESS<br>AMELIA M. PICK 4012 LINKWOOD RD. 21210   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>4413 IMMEDIATE CAUSE (a) Cardiac asystole<br>DUE TO, OR AS A CONSEQUENCE OF (b) Acidosis<br>DUE TO, OR AS A CONSEQUENCE OF (c) Renal failure & respiratory failure<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br>Pneumonia & Renal failure. |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br>11/30/82  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Ruptured Abdominal Aorta  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/1/83, to 1/28/1983, that (I) (we) last saw the deceased alive on 1/28/1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |
| 22b. SIGNATURE S. Aghazarian M.D.   |  |   |  | 22c. DATE SIGNED 1/28/83  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SARKIS AGHAZARIAN   |  |
| 22e. ADDRESS 201 E. UNIVERSITY PARKWAY  |  |   |  | 22f. ADDRESS  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>CREMATION  |  | 23b. DATE<br>JAN. 29, 1983  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GREEN MOUNT CEM.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTIMORE MD.  |  |
| 24. FUNERAL DIRECTOR NAME<br>MITCHELL-WIEDEFELD HOME  |  |   |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>FEB 4 1983  |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH-16 25M  
(VRA 15, 4) 1/79

| FOR<br>1 - STATE<br>REGISTRAR  |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 3 0 1 2 6 7<br>REG. NO.  |  |   |  |                            |  |
|--|--|---|--|--|--|--|--|--|--|---|--|----------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  | 2a DATE OF DEATH   |  |  |  | 2b HOUR  |  |   |  |                            |  |
| FIRST MIDDLE LAST<br>ALTHEA PIGFORD  |  |   |  | MONTH DAY YEAR<br>1/25/83  |  |  |  | 6:30 P M   |  |   |  |                            |  |
| 3 SEX  |  | 4 RACE  |  | 5. DATE OF BIRTH   |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS   |  |                            |  |
| Female   |  | Black   |  | MONTH DAY YEAR<br>1 14 24  |  | 59 YRS   |  | MONTHS DAYS  |  | HOURS MIN   |  |                            |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |   |  |                            |  |
| S. Carolina  |  | U.S.A.  |  |  |  | Baltimore City, MD.  |  |  |  |   |  |                            |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b KIND OF BUSINESS OR INDUSTRY                                    |  |                            |  |
| Baltimore  |  | Baltimore City, Hospital  |  |  |  |  |  |  |  |   |  |                            |  |
| 13a STATE  |  |   |  | 13b COUNTY   |  | 13c CITY OR TOWN   |  | 13d INSIDE CITY LIMITS?  |  |   |  | 13e STREET ADDRESS         |  |
| Maryland   |  |   |  |  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 474 Manse Ct. 21201   |  |                            |  |
| 14 FATHER'S NAME   |  |   |  | 15 MOTHER'S MAIDEN NAME  |  |  |  |  |  |   |  |                            |  |
| FIRST MIDDLE LAST<br>Sylvester Pigford   |  |   |  | FIRST MIDDLE LAST<br>Alice Leggett   |  |  |  |  |  |   |  |                            |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   |  | 16b SOCIAL SECURITY NO   |  | 17 INFORMANT ADDRESS   |  |  |  |   |  |                            |  |
| No   |  |   |  | 088-16-4344  |  | Elizabeth Baker 542 W. Preston St.   |  |  |  |   |  |                            |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY   |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                     |  |                            |  |
| IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest / Resp Compromise</u>  |  |   |  |  |  |  |  |  |  | 15-30 sec   |  |                            |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe Metabolic Acidosis</u>  |  |   |  |  |  |  |  |  |  | 1-2 hrs   |  |                            |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Gangrene / Ca of lung / Periph Vasc Dis.</u>   |  |   |  |  |  |  |  |  |  | gangrene cancer<br>72 wks / > 1 yr                                  |  |                            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>none</u>   |  |   |  |  |  |  |  |  |  |   |  |                            |  |
| 19a DATE OF OPERATION  |  |   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a AUTOPSY?   |  | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?    |  |                            |  |
| 1/18/83  |  |   |  | Severe Peripheral Vascular Disease   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |   |  |                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |   |  |                            |  |
|  |  |   |  |  |  |  |  |  |  |   |  |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/25</u> 19 <u>83</u> , to <u>1/25</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>1/25</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |  |  |   |  |                            |  |
| 22b. SIGNATURE   |  |   |  | DEGREE   |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED  |  |                            |  |
| Greenberg  |  |   |  |  |  |  |  |  |  | 1/25/83   |  |                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 22e. ADDRESS   |  |  |  |  |  |   |  |                            |  |
| MARTIN GREENBERG   |  |   |  | BALT. CITY HOSPITAL  |  |  |  |  |  |   |  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |   |  |                            |  |
| BURIAL   |  |   |  | 1/29-83  |  | Eastview Mem. Pk.  |  | Baltimore Co. Md.  |  |   |  |                            |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS  |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |  |  |   |  | 25b. REGISTRAR'S SIGNATURE |  |
| Wm. C. March F/H Inc. 1101 E. North Ave.   |  |   |  |  |  | JAN 27 1983  |  |  |  |   |  | John J. Carver             |  |

MEDICAL CERTIFICATION

RECEIVED  
JAN 10 1963



RECEIVED  
JAN 10 1963

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 2 6 8

FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |  |  |                             |
|--|---|---|--|--|-----------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JAAN - Pihelgas   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1-27-83   |  | 2b. HOUR<br>9:35 A.M.       |
| 3. SEX<br>Male   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 29, 1896   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>YRS.  |                             |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Estonia   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>City MD.   |  |                             |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Mercy Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Ret. Executive   | 12b. KIND OF BUSINESS OR INDUSTRY  |                             |
| 13a. STATE<br>Md.  | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 13e. STREET ADDRESS<br>2614 Evergreen Ave. 21214   |                             |
| 14. FATHER'S NAME<br>Jaani   | MIDDLE Pihelgas   | LAST  | 15. MOTHER'S MAIDEN NAME<br>Mari   | MIDDLE Rouk  | LAST                        |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-30-6515A   | 17. INFORMANT<br>Green Arm, Md.<br>Mrs. Irene Vaigro 2700 Long Green Rd.  |  |  |                             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>4100 IMMEDIATE CAUSE (a) Acute Myocardial Infarction<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>72 hours |   |   |  |  |                             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).<br>Multiple Cerebrovascular Accidents  |   |   |  |  |                             |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                             |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |                             |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                             |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-25, 1983, to 1-27, 1983, that (I) (we) lost<br>saw the deceased alive on 1-27, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death.   |   |   |  |  |                             |
| 22b. SIGNATURE<br>Constance J. Meyd MD   |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>1-27-83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Constance J. Meyd   |   |   | 22e. ADDRESS<br>Mercy Hospital Balto Md  |  |                             |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  | 23b. DATE<br>Jan. 31, 1983  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland   |                             |
| 24. FUNERAL DIRECTOR<br>Leonard J. Ruck Inc. Baltimore, Maryland   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 28 1983   |  |                             |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be required to sign.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

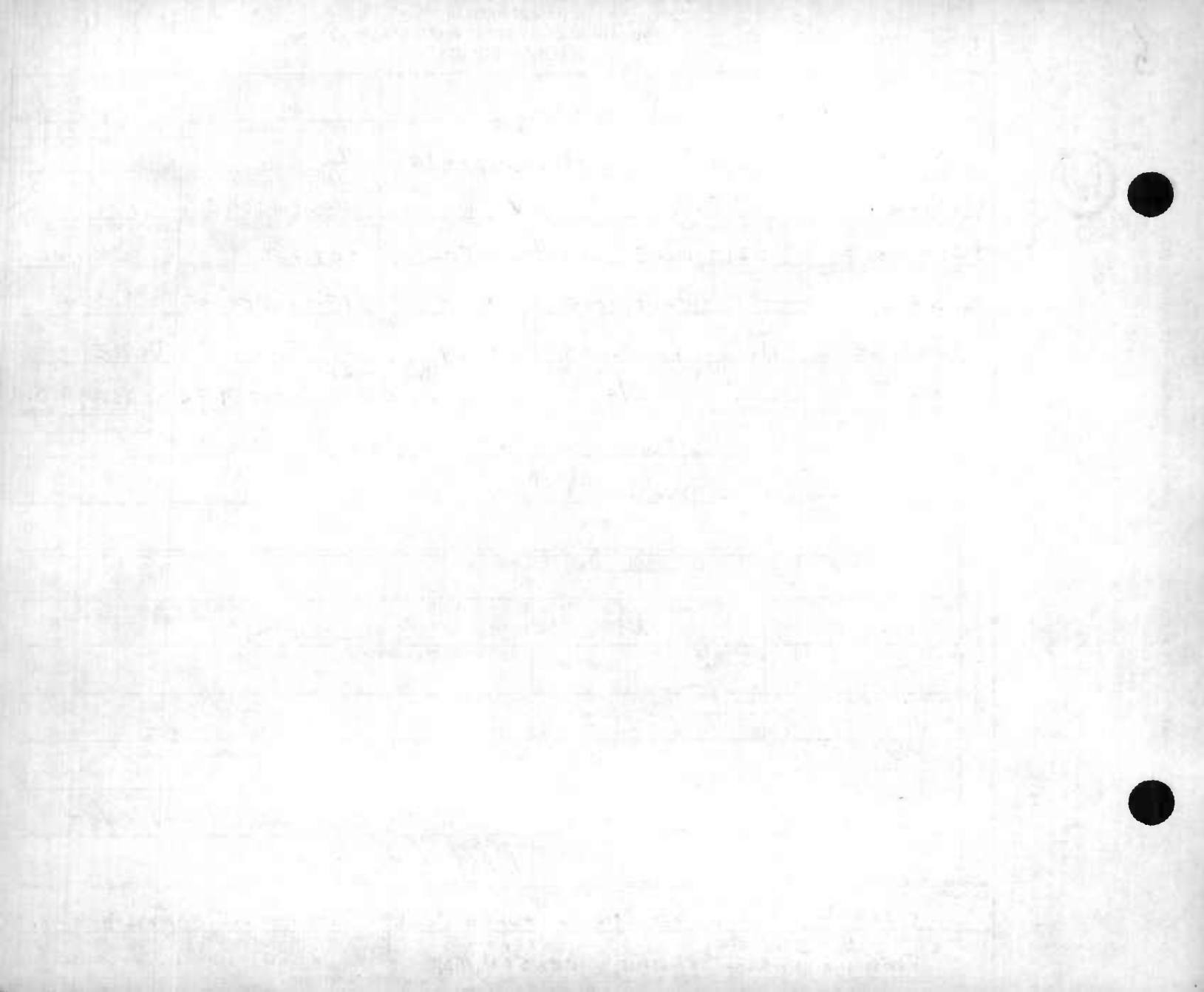
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 2 6 9

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Hayden Pingley</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 2 83</b>  |  | 2b. HOUR<br><b>7:05 PM</b>                                       |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>FEB. 26, 1890</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>92</b> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>W. VIRGINIA</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE CITY HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>COAL MINER</b>           |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>   |   |   | 13b. COUNTY<br><b>BALTIMORE</b>   |  |  |
| 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 13e. STREET ADDRESS<br><b>3130 FAIT AVE</b>   |   |   | 13f. CITY OR TOWN<br><b>BALTIMORE</b>   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GEORGE W. PINGLEY</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY E. DOYLE</b>                           |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   |   | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>  |  |  |
| 17. INFORMANT (DAUGHTER)<br><b>MRS. GENEVIEVE VANDEVENDER</b>   |   |   | ADDRESS<br><b>BALTO, MD.</b>  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>1539</b> IMMEDIATE CAUSE (a) <b>Cardiovascular collapse, metabolic acidosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Dissecting Aortic Aneurysm</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Dissecting Aortic Aneurysm</b>  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |   |   |   |  |  |
| 19a. DATE OF OPERATION<br><b>12/29</b>  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Colon resection</b>  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/28</b> 19 <b>82</b> , to <b>1/2</b> 19 <b>83</b> , that (we) last saw the deceased alive on <b>1/2</b> 19 <b>83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Thomas Green</b>   |   | DEGREE<br><b>ATTENDING PHYSICIAN</b>  |   | 22c. DATE SIGNED<br><b>1/2/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Thomas Green</b>  |   | 22e. ADDRESS<br><b>Balt. City Hosp.</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |   | 23b. DATE<br><b>1/6/83</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BRICK CHURCH CEM.</b>                       |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>HUTTONSVILLE RANDOLPH W. VA.</b>   |   |   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>E. BARNES</b>  |   | ADDRESS<br><b>21018 BENSON, MD.</b>   |   | 25a. DATE<br><b>JAN 5 1983</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>   |   |   |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| Items 13a-e per phone 2/2/83 dad STATE OF MARYLAND  |  |   |  |  |   |  |  |   |  |
|---|--|---|--|--|---|--|--|---|--|
| FOR<br>1. STATE<br>REGISTRAR  |  |   |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH           |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  |  | 2a. DATE OF DEATH   |  |  |   |  |
| FIRST MICHÉLLE MIDDLE D. LAST PINKNEY<br>BABY GIRL PINKNEY  |  |   |  |  | MONTH DAY YEAR<br>1-26-83   |  |  |   |  |
| 3 SEX<br>FEMALE   |  |   |  |  | 2b. HOUR<br>11:30 A.M.  |  |  |   |  |
| 4 RACE<br>BLACK   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>1 26 83  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS                                   |  | IF UNDER 24 HRS.<br>HOURS MIN.                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.        |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>PROVIDENT HOSPITAL |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                   |  |
| 13a. STATE<br>Md.   |  | 13b. CITY OR TOWN<br>Baltimore  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13d. STREET ADDRESS<br>2617 N. Calvert Street                    |  |   |  |
| 14. FATHER'S NAME<br>FIRST MITCHELL MIDDLE PINKNEY LAST MICHELL   |  |   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST D. MIDDLE PINKNEY LAST                  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No #  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS<br>21218<br>Mitchell W. Pinkney 2617 N. Calvert Street   |   |  |  |   |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u><br><u>7651</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>NON VIABILITY</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>SEVERE IMMATURITY</u> |  |   |  |  |   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |  |  |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-26-83</u> , 19 <u>83</u> , to <u>1-26</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>1-26</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |   |  |  |   |  |
| 22b. SIGNATURE<br><u>Patricia L. Saloana M.D.</u>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |   | 22c. DATE SIGNED<br><u>1-27-83</u>                               |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>PATRICIA L. SALOANA</u>   |  |   |  | 22e. ADDRESS<br><u>PROVIDENT HOSPITAL</u><br><u>2600 Liberty Hts. Balto. Md. 21215</u>   |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>1-29-1983  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Pleasant Rest  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Towson Maryland    |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Ruck Towson Funeral Home, Inc., Towson, Maryland  |  |   |  | ADDRESS<br>1050 York Road  |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 28 1983                     |  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Church</u> |  |





Items 11a-22a Film G577 3/9/83 re STATE OF MARYLAND

FOR  
1- STATE REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3 0 1 2 7 1

|  |                  |  |  |   |   |   |                                   |   |  |
|--|------------------|--|--|---|---|---|-----------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>VERONICA V. PINKNEY   |                  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> 1-28-83 <sub>19</sub> |   |   | 2b. HOUR<br>M   |                                   |   |  |
| 3. SEX<br>Female   | 4. RACE<br>Black | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 30 62  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>20 YRS.  | 7. IF UNDER 24 YR.<br>MONTHS DAYS HOURS MIN.  | 7c. DATE PRONOUNCED DEAD<br>1-28-83 <sub>19</sub>                             | 2d. HOUR<br>1:15 PM   |                                   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |                                   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinai Hospital |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |   | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| 13a. STATE<br>MD   |                  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   | 13e. STREET ADDRESS<br>3029 Wylie Avenue 21215                                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Milton Pinkney Jr.   |                  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Barbara Robinson   |   |   |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |                  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A   |  | 17. INFORMANT<br>ADDRESS<br>Milton Pinkney 1509 E. Lafayette A  |   |   |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Hydrocephalus secondary to aqueductal stenosis with complications<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |                  |  |  |   |   |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                  |  |  |   |   |   |                                   |   |  |
| 19a. DATE OF OPERATION   |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |   |                                   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                     |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |                                   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                    |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |                                   |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |  |  |   |   |   |                                   |   |  |
| ACTUAL SIGNATURE<br>Margarita A. Korell, M.D.  |                  |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER   |   |   |   | DATE SIGNED<br>1-29-83            |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |                  |  | ADDRESS<br>111 Penn Street   |   |   |   |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |                  | 23b. DATE<br>2/4/83  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Calvary Cem.  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY<br>Anne Arundel Co. MD                                     |                                   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H   |                  |  |  | ADDRESS<br>1101 E. North Ave.   |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 2 1983   |                                   | 25b. REGISTRAR'S SIGNATURE<br>John J. Carver  |  |



DIVISION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|---|--|
| 1- FOR STATE REGISTRAR   |  |   |  |   |  |   |  |   |  |
| REG. NO. 83 01272  |  |   |  |   |  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>DALE E. PITCHER   |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>January 30, 1983 |   |  | 2b. HOUR<br>4 P M   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 6, 1913  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Illinois  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2705 St. Paul Street |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clergy                      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Church   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>2705 St. Paul St. 21218  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Pitcher   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Fannie Baker   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  |   |  | 16b. SOCIAL SECURITY NO.<br>370 01 0732   |  | 17. INFORMANT<br>Mrs. Dale E. Pitcher,  |  | ADDRESS<br>Same   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>metastatic Prostatic Carcinoma</u><br>1850<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>10/18</u> , 19 <u>83</u> , to <u>1/30</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>1/28</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.             |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Davis Hahn</u>  |  |   |  | DEGREE<br>MD  |  |   |  | 22c. DATE SIGNED<br>1/31/83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Davis Hahn, M. D.   |  |   |  | 22e. ADDRESS<br>5601 Loch Raven Blvd., Balto., MD   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |  | 23b. DATE<br>2/1/83   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., MD  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME Henry W. Jenkins & Sons Co.<br>ADDRESS 4905 York Road Balto., MD 21212  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 1 1983   |  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Connel</u>   |  |

BP



DATE: JAN 10, 1913

TO: FITCHER

FROM: J. H. HANCOCK

RE: BILLY'S

THANKS

Yours truly,

J. H. HANCOCK

Wm. H. HANCOCK

Wm. H. HANCOCK

Wm. H. HANCOCK

Wm. H. HANCOCK

Wm. H. HANCOCK

Wm. H. HANCOCK

Wm. H. HANCOCK

Wm. H. HANCOCK

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Wm. H. HANCOCK

Wm. H. HANCOCK

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8301273

FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |  |   |  |
|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOA E. PLAINE</b>  |   |   | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>14</b> YEAR <b>83</b>                     |   | 2b. HOUR<br><b>1100</b>  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH <b>9</b> DAY <b>29</b> YEAR <b>95</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, City</b> MD.                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore General</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>Maryland</b>   |   | 13b. COUNTY<br><b></b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST <b>Unknown</b> MIDDLE <b>--</b> LAST <b>Gregory</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Ella</b> MIDDLE <b>--</b> LAST <b>Unknown</b>  |  | 13e. STREET ADDRESS<br><b>304 E. Randall St. Balto. Md. 21230</b>                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>214-30-6030</b>  |  | 17. INFORMANT<br>ADDRESS <b>Mr. Robert W. Plaine, 210 Benmere Rd. Glen Burnie Md. 21061</b>     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4029</b> IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MIASCVD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>1113</b> P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/13</b> 19 <b>83</b> to <b>1/14</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1/13</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (if we) (did not) view the body after death.                                      |   |   |  |   |  |
| 22b. SIGNATURE<br><b>M. McCarthy</b>  |   | DEGREE  |  | 22c. DATE SIGNED<br><b>1/14/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MCCARTHY</b>  |   | 22e. ADDRESS<br><b>3001 S. Hanover ST</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>Jan. 18, 1983</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                        |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>McCutty Funeral Home, 130 E. Fort Ave. Balto. Md.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 19 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 2 7 4

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>NORMAN PLEASANT</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01 13 83</b>  |  | 2b. HOUR<br><b>12:25 AM</b>  |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 29 25</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS HOURS MIN.<br><b>57</b>    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N. Caroline</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.              |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CATON MANOR NURSING HOME</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>---</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>  |
| 13a. STATE<br><b>Maryland</b>  | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>3330 Wilkens Avenue 21229</b>                        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR NO IF UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>YES 1952-1957</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>243-20-5155</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Pat Weiford 3330 Wilkens Avenue 21229</b>       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4140 IMMEDIATE CAUSE (a) Cardiac arrhythmia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a)<br><b>Right Below Knee Amputation. Right Hemiplegia. Seizure disorder.</b>  |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-31-82</b> to <b>1-13-83</b> , that (I) (we) lost<br>saw the deceased alive on <b>12-31-82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |  |  |
| 22b. SIGNATURE<br><b>S. Dev Auja</b>   |  | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>1/13/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>S. DEV AUJIA, M.D.</b>   |  | 22e. ADDRESS<br><b>5400 OLD COURT ROAD; RANDALLSTOWN, MD. 21133</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>1/17/83</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crownsville Vet. Cem. Crownsville</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>A.A. Maryland</b>             |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.</b>  |  | ADDRESS<br><b>21229</b>   |   | 25. DATE REC'D. BY REGISTRAR<br><b>JAN 17 1983</b>                             |  |

MEDICAL CERTIFICATION

9 9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP



100-443887-100

881500

19

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called for an autopsy.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  | 83 01 27 5   |  |
|---|--|--|--|---|--|---|--|--|--|--|--|
| FOR<br>1 - STATE REGISTRAR  |  |  |  |   |  |   |  |  |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CHARLES POLCAK</b>   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01 03 83</b>  |  | 2b. HOUR<br><b>2:13 AM</b>   |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>06 18 10</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MEAT CUTTER</b>          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>MEAT CO.</b>   |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>A.A.</b>   |  | 13c. CITY OR TOWN<br><b>LINTHICUM HEIGHTS</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>694 N. MIDFIELD ROAD 21090</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>THOMAS POLCAK</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ROZ INA ZEDEDIA</b>   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-07-0301</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>EVELYN M. POLCAK 694 N. MIDFIELD ROAD LINTHICUM HGTS.</b>  |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4100 IMMEDIATE CAUSE (a) Cardiac arrest - Ventricular Fibrillation</b>   |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hours</b> |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Myocardial Infarction</b>  |  |  |  |   |  |   |  |  |  | <b>2 days</b>  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Atherosclerotic Coronary disease</b>   |  |  |  |   |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>not applicable.</b>   |  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>not applicable.</b>  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>not applicable</b>   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>01-01-1983</b> to <b>01-03-1983</b> , that I (we) last saw the deceased alive on <b>01-03-1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>George J. Vellankaran</b>  |  |  |  | DEGREE<br><b>MD</b>   |  |   |  | 22c. DATE SIGNED<br><b>1-3-83</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GEORGE VELLANKARAN</b>  |  |  |  | 22e. ADDRESS<br><b>St. Agnes Hospital Baltimore, MD-21228</b>   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>01-05-83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b>                    |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.</b>   |  |  |  | ADDRESS<br><b>21229</b>   |  | 25a. DATE RECEIVED BY REGISTRAR<br><b>JAN 5 1983</b>  |  |  |  |  |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>   |  |   |  |  |  |  |  |

BP \_\_\_\_\_



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 2 7 6

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |   |   |  |   |  |
|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CHARLES A. POOLE</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>1-4-83</b>                                    |   | 2b. HOUR<br><b>1 P.M.</b>                      |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>BLACK</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>11 23 51</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>31</b> YRS.   | # UNDER 1 YEAR<br>MONTHS DAYS                  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>      | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO.</b> MD.                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTO. CITY HOSP.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Bethlehem</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>STEEL</b>   |  |
| 13a. STATE<br><b>MD.</b>                                     |   | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>BALTO.</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>1402 LINWOOD AVE</b> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HOMER POOLE</b> |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY ROBINSON</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>YES</b>                 |  |
| 16b. SOCIAL SECURITY NO.<br><b>213-52-9521</b>               |   | 17. INFORMANT<br><b>MR. HOMER POOLE - 1402 LINWOOD AVE</b>  |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

**4275**  
IMMEDIATE CAUSE (a) **CARDIAC ARREST**  
DUE TO, OR AS A CONSEQUENCE OF  
(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF  
(c) \_\_\_\_\_

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**HEP B & ALG** **ARTERITIS**

|  |  |  |   |
|--|--|--|---|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |

22a. I certify that (I) (this hospital) attended the deceased from **12-31**, 19 **82**, to **1-4**, 19 **83**, that (I) (we) last saw the deceased alive on **1-4**, 19 **83**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

|  |  |                  |
|--|--|------------------|
| 27b. SIGNATURE<br><b>M. Korytkowski</b>                          | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 27c. DATE SIGNED |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARY KORYTKOWSKI</b> | 27e. ADDRESS<br><b>BCH</b>   |                  |

|  |                            |  |  |
|--|----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>                       | 23b. DATE<br><b>1-7-83</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crownsville Vet. Cem.</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crownsville MD.</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Redd Funeral Home - 5209 YORK RD.</b> |                            | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 10 1983</b>                | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

7

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |   |   |  |   |   |  |  |
|--|--|---|--|--|---|---|--|---|---|--|--|
| 1- FOR STATE REGISTRAR   |  | REG. NO. 83 01277   |  |  |   |   |  |   |   |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>CHARLES E. POWELL  |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>1 19 83 |   |  |   |   | 2b. HOUR<br>12 07 PM                   |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Aug. 6, 1919  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS.   |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A. |  |
| 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE, CITY MD.  |  |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Executive |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Advertising  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  |  |   |   | 13a. STREET ADDRESS<br>90 Padonia Road                                     |   | 13b. CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 21093 |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Carrie James   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes   |   | 16b. SOCIAL SECURITY NO.<br>W.W. II 217-07-6227                                   |  | 17 INFORMANT ADDRESS<br>Mindy T. Powell 21093 90 Padonia Rd. Lutherville, MD  |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>4310 IMMEDIATE CAUSE (a) Posterior cerebellar bleed<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }<br>DUE TO, OR AS A CONSEQUENCE OF (b) Bicuspid spontaneous vessel rupture.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 day |  |   |  |  |   |   |  |   |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |   |   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)   |   |   |  |   |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |   |  |   |   |  |  |
| 22a. I certify that (a) (this hospital) attended the deceased from 1/18, 19 83, to 1/19, 19 83, that (b) (we) lost the deceased alive on 1/19, 19 83, and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (D) (we) (did) (did not) view the body after death.   |  |   |  |  |   |   |  |   |   |  |  |
| 22b. SIGNATURE<br>Paul Miller MD   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   |  | 22c. DATE SIGNED<br>1/19/83   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PAUL MILLER, M.D.   |  |   |  | 22e. ADDRESS<br>201 E. University Pkwy. Balto. Md. 21218   |   |   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>Jan. 22, '83   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Mem. Gar.   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Co., MD                      |  |   |   |  |  |
| 24 FUNERAL DIRECTOR NAME<br>William E. Johnson   |  |   |  | ADDRESS<br>8521 Loch Raven Blvd.   |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 20 1983  |   |  |  |
|  |  |   |  |  |   |   |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Carver  |   |  |  |

BP





JAN 30 1969  
J. L. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Baltimore Health Department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |  |   |  |   |  | 8 3 0 1 2 7 8  |  |
|---|--|--|--|--|--|---|--|---|--|--|--|
| FOR<br>1 - STATE REGISTRAR  |  |  |  | CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH  |  |   |  | 2b. HOUR  |  |  |  |
| FIRST MIDDLE LAST   |  |  |  | MONTH DAY YEAR   |  |   |  | MONTH DAY YEAR  |  |  |  |
| Elsie V. Poling   |  |  |  | 1 6 83   |  |   |  | 330 <sup>PM</sup>   |  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | 7. IF UNDER 1 YEAR  |  | 7. IF UNDER 24 HRS.  |  |
| Female  |  | White  |  | MONTH DAY YEAR   |  | 55 YRS.   |  | MONTHS DAYS   |  | HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |   |  |  |  |
| Maryland  |  | U.S.A.   |  |  |  | Baltimore City MD.  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |
| Baltimore   |  | Baltimore City Hospital  |  |  |  | Lunch Wagon Driver  |  |   |  |  |  |
| 13a. STATE  |  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  |  |  |
| Maryland  |  |  |  | Baltimore  |  | Dundalk   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS  |  |
|   |  |  |  |  |  |   |  | 101 Center Pl. Apt-501  |  | 21222  |  |
| 14. FATHER'S NAME   |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |  |  |  |
| FIRST MIDDLE LAST   |  |  |  | FIRST MIDDLE LAST  |  |   |  |   |  |  |  |
| Royce   |  |  |  | Pettie   |  |   |  | Viola Campbell  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | 17a. ADDRESS  |  |  |  |
| No  |  |  |  | 215-22-7082  |  | Melva J. Smith  |  | 16511 Dezavalla Channelview, Texas 77530                            |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>4275 IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  |  |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
|   |  |  |  | HOUR A.M. MONTH DAY YEAR   |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED  |  |  |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION   |  | 21g. DATE SIGNED  |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | STREET CITY OR TOWN COUNTY STATE  |  | 16/83   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/6 1983 to 1/12/83, that (I) (we) lost the deceased alive on 1/6 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (and not) view the body after death.   |  |  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE  |  |  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  |  |  |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22d. ADDRESS   |  |   |  |   |  |  |  |
| Charles Van Hook  |  |  |  | Baltimore City   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |  | 23e. COUNTY STATE  |  |
| Burial  |  |  |  | 1/12/1983  |  | Payne Cemetery  |  | Fairfax   |  | W. Virginia  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222   |  |  |  |  |  | JAN 11 1983   |  | [Signature]   |  |  |  |

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Page 1 of 1

entire

chief



CHIEF

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 2 7 9

REG. NO.

|   |   |   |  |  |  |   |  |
|---|---|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   | FIRST MIDDLE LAST   |  | 20. DATE OF DEATH MONTH DAY YEAR   |  | 2b. HOUR  |  |
| EARL POWELL   |   |   |  | 01/18/83   |  | 4:55p   |  |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. IF UNDER 1 YEAR  |  |
| male  | Black   | MONTH DAY YEAR<br>3 6 17  |  | 65 YRS.  |  | MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |
| Maryland  | U.S.A.  |   |  | BALTIMORE CITY MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| BALTIMORE   | THE JOHNS HOPKINS HOSPITAL  |   |  |  |  |   |  |
| 13a. STATE  |   | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  |
| Maryland  |   |   |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME   |   | 15. MOTHER'S MAIDEN NAME  |  | 13e. STREET ADDRESS  |  |   |  |
| FIRST MIDDLE LAST   |   | FIRST MIDDLE LAST   |  | 1119 N. Bradford St. 21213   |  |   |  |
| Alfred Powell   |   | Wiliamenia Sage   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |  |   |  |
| Yes   |   | 217-07-0547   |  | Roslie Powell 1119 N. Bradford Street  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory arrest</u><br><u>4310</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Raised intracranial pressure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Subdural hemorrhage</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Anticoagulant therapy for prothetic valve</u>   |   |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|   |   |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |
|   |   |   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 17</u> , 19 <u>83</u> , to <u>Jan 18</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>Jan 18</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |  |  |  |   |  |
| 22b. SIGNATURE  |   | DEGREE  |  | 22c. DATE SIGNED   |  |   |  |
| <u>Daniel E Ford</u>  |   | M.D.  |  | 1/18/83  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |   | 22e. ADDRESS  |  |  |  |   |  |
| DANIEL E FORD   |   | JOHNS HOPKINS HOSPITAL  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL   |   | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |
| BURIAL  |   | 1/21/83   |  | Md. Veteran Ceme   |  | Crownsville Md.   |  |
| 24. FUNERAL DIRECTOR  |   | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |
| NAME  |   | 1101 E. North Avenue  |  | JAN 20 1983 <u>John J. Conner</u>  |  |   |  |
| Wm. C. March F/H Inc  |   |   |  |  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or after traumatic event, the medical examiner must be notified at once.

NOV 15 1964



WATERBURY, CT. 06705

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| 1- STATE REGISTRAR  |  | PAULINE T. POWELL |  | STATE OF MARYLAND   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE |  | 8 3 0 1 2 8 0   |  | CERTIFICATE OF DEATH   |  | REG. NO.  |  |                  |  |
|---|--|-------------------|--|---|--|---|--|---|--|------------------------|--|---|--|------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)  |  |                   |  | PAULINE T. POWELL   |  |   |  | 2a. DATE OF DEATH   |  |                        |  | MONTH DAY YEAR HOUR   |  |                  |  |
|   |  |                   |  |   |  |   |  | 1 8 83  |  |                        |  | 9:45 P.M.   |  |                  |  |
| 3. SEX  |  | FEMALE            |  | 4. RACE   |  | WHITE                                   |  | 5. DATE OF BIRTH  |  | 07 <sup>TH</sup> 23 30 |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 52               |  |
|   |  |                   |  |   |  |   |  |   |  |                        |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS. |  |
|   |  |                   |  |   |  |   |  |   |  |                        |  | MONTHS DAYS   |  | HOURS MIN.       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)   |  |                   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                        |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                  |  |
| MARYLAND  |  |                   |  | USA   |  |   |  |   |  |                        |  | BALTIMORE CITY MD   |  |                  |  |
| 10. CITY OR TOWN OF DEATH   |  |                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION             |  |   |  | 12a. USUAL OCCUPATION (TYPE & WORK FOR MOST OF WORKING LIFE)  |  |                        |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                  |  |
| BALTIMORE   |  |                   |  | BALTO. CITY HOSPITAL  |  |   |  | HOUSEWIFE   |  |                        |  | ---   |  |                  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                   |  | 13b. COUNTY   |  |   |  | 13c. CITY OR TOWN   |  |                        |  | 13d. INSIDE CITY LIMITS?  |  |                  |  |
| MARYLAND  |  |                   |  | ---   |  |   |  | BALTIMORE   |  |                        |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                  |  |
| 14. FATHER'S NAME   |  |                   |  | 15. MOTHER'S MAIDEN NAME  |  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> IF UNKNOWN)  |  |                        |  | 16b. SOCIAL SECURITY NO.  |  |                  |  |
| SEBASTIAN   |  |                   |  | GREISER   |  |   |  | IRENE   |  |                        |  | 218266592   |  |                  |  |
|   |  |                   |  |   |  |   |  |   |  |                        |  | 17. INFORMANT ADDRESS   |  |                  |  |
|   |  |                   |  |   |  |   |  |   |  |                        |  | SAMUEL POWELL 500 N. PORT ST.                                       |  |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY:   |  |                   |  |   |  |   |  |   |  |                        |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |                  |  |
| IMMEDIATE CAUSE (a) <u>Respiratory arrest</u>   |  |                   |  |   |  |   |  |   |  |                        |  | Immediate   |  |                  |  |
| 1919 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Glioblastoma multiforme</u>  |  |                   |  |   |  |   |  |   |  |                        |  | 1 month   |  |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____  |  |                   |  |   |  |   |  |   |  |                        |  |   |  |                  |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |                   |  |   |  |   |  |   |  |                        |  |   |  |                  |  |
| 19a. DATE OF OPERATION  |  |                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |   |  | 20a. AUTOPSY?   |  |                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                  |  |
|   |  |                   |  |   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                        |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                   |  | 21b. TIME OF INJURY   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  |                        |  |   |  |                  |  |
|   |  |                   |  | HOUR A.M. MONTH DAY YEAR  |  |   |  |   |  |                        |  |   |  |                  |  |
|   |  |                   |  | P.M. 19   |  |   |  |   |  |                        |  |   |  |                  |  |
| 21d. INJURY OCCURRED  |  |                   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   |  | 21f. LOCATION   |  |                        |  |   |  |                  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                   |  |   |  |   |  | STREET  |  |                        |  | CITY OR TOWN COUNTY STATE   |  |                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-28</u> , 19 <u>82</u> , to <u>1-8</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>1-8</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                   |  |   |  |   |  |   |  |                        |  |   |  |                  |  |
| 22b. SIGNATURE  |  |                   |  | DEGREE  |  |   |  | 22c. DATE SIGNED  |  |                        |  |   |  |                  |  |
| Michael Rogawski  |  |                   |  | MD  |  |   |  | 1/8/83  |  |                        |  |   |  |                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |                   |  | 22e. ADDRESS  |  |   |  | 22f. DATE REC'D. BY REGISTRAR   |  |                        |  | 22g. REGISTRAR'S SIGNATURE  |  |                  |  |
| MICHAEL A. ROGAWSKI   |  |                   |  | JOHNS HOPKINS HOSPITAL  |  |   |  |   |  |                        |  |   |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |                   |  | 23b. DATE   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |                        |  | 23d. LOCATION   |  |                  |  |
| BURIAL  |  |                   |  | 1/12/83   |  |   |  | GARDENS OF FAITH CEME.  |  |                        |  | CITY OR TOWN COUNTY STATE   |  |                  |  |
|   |  |                   |  |   |  |   |  | BALTO. MD.  |  |                        |  |   |  |                  |  |
| 24. FUNERAL DIRECTOR  |  |                   |  | ADDRESS   |  |   |  | 25a. DATE REC'D. BY REGISTRAR   |  |                        |  | 25b. REGISTRAR'S SIGNATURE  |  |                  |  |
| John C. Cook  |  |                   |  | 1211 Chesapeake Ac. - 21237   |  |   |  | JAN 10 1983   |  |                        |  | John C. Cook  |  |                  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   | 8 3 0 1 2 8 1  |  |  |  |   |  |  |
|--|--|--|--|---|--|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   | REG. NO.   |  |  |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Carl Prehn</b>  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>4</b> YEAR <b>83</b><br>7b. HOUR <b>7:50am</b>  |  |  |  |   |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>1</b> DAY <b>6</b> YEAR <b>1896</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b>   |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN. <b>0</b>  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Germany</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                      |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Brick Layer</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Self Employed</b>  |   |  |  |
| 13a. STATE<br><b>Maryland</b>  |  |  |  |   | 13b. COUNTY<br><b>Anne Arundel</b>   |  | 13c. CITY OR TOWN<br><b>Hanover</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Detlev</b> MIDDLE <b>Prehn</b> LAST <b>Prehn</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Anna</b> MIDDLE <b>Dohrman</b> LAST <b>Dohrman</b>  |  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |  |  |  |   | 16b. SOCIAL SECURITY NO.<br><b>217-32-1798</b>   |  | 17. INFORMANT<br><b>Herman F. Prehn</b>  |  |   | ADDRESS<br><b>1723 Maple Avenue 21076</b>    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4310</b> IMMEDIATE CAUSE (a) <b>Massive Bilateral Cerebral hemorrhage</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Coumadin therapy &amp; probably</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Previous CVA, Chronic Atrial fibrillation</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Previous CVA, Chronic Atrial fibrillation</b> |  |  |  |   |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>      |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)         |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                      |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-3-83</b> , <b>1983</b> , to <b>1-4</b> , <b>1983</b> , that (I) (we) lost<br>saw the deceased alive on <b>1-4</b> , <b>1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |  |   | 22c. DATE SIGNED<br><b>1-4-83</b>            |  |
| 22b. SIGNATURE<br><b>P. V. Kanani</b>  |  |  |  |   | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>P. KANANI, M.D.</b>  |  |  |  |   | 22e. ADDRESS<br><b>St. Agnes Hospital</b>  |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>1/7/83</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Mem. Pk.</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>Elkridge</b> COUNTY <b>Howard</b> STATE <b>Maryland</b> |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Hubbard Funeral Home, Inc.</b> ADDRESS <b>4107 Wilkens Ave.</b>  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 7 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |  |

1 4 5:20am

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |         |                  |  |                   |                     |   |  |  |  |  |  |
|---|---------|------------------|--|-------------------|---------------------|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)       |         |                  | 20. DATE KNOWN OF DEATH                                  |                   |                     | 21. DATE OF DEATH   |  |  | 22. HOUR   |  |  |
| Deserra C. Press                          |         |                  | 12 20 55   |                   |                     | 27 YRS.   |  |  | 1 26 19 83   |  |  |
| 3. SEX                                    | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY)                          | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS. | 21. DATE OF DEATH   |  |  | 22. HOUR   |  |  |
| F   | Black   | 12 20 55         | 27 YRS.  |                   |                     | 1 26 19 83  |  |  | 8:45 P M   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) |         |                  | 7b. CITIZEN OF WHAT COUNTRY?                             |                   |                     | 8. MARRIED  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                     |  |  |
| Danville, VA.                             |         |                  | yes  |                   |                     | NEVER MARRIED   |  |  | Baltimore City   |  |  |
| 10. CITY OR TOWN OF DEATH                 |         |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |                   |                     | 12a. USUAL OCCUPATION                                     |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| Baltimore                                 |         |                  | 2805 Gatehouse Drive                                     |                   |                     | TEACHER   |  |  |  |  |  |
| 13a. STATE                                |         |                  | 13b. COUNTY  |                   |                     | 13c. CITY OR TOWN   |  |  | 13d. INSIDE CITY LIMITS?   |  |  |
| MD  |         |                  |  |                   |                     | Balto.  |  |  | YES NO   |  |  |
| 14. FATHER'S NAME                         |         |                  | 15. MOTHER'S MAIDEN NAME                                 |                   |                     | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?              |  |  | 16b. SOCIAL SECURITY NO.   |  |  |
| William C. Johnson                        |         |                  | Lillian White  |                   |                     | NO  |  |  | 213-64-5731  |  |  |
| 17. INFORMANT                             |         |                  | 18. CAUSE OF DEATH                                       |                   |                     | 19. DATE OF OPERATION                                     |  |  | 20. AUTOPSY?   |  |  |
| Dwane Press                               |         |                  | Gunshot wound of chest                                   |                   |                     | 19 23 P.M.  |  |  | YES NO   |  |  |
| 3721 Hilldale Rd.                         |         |                  | PART 1 DEATH WAS CAUSED BY:                              |                   |                     | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH |  |  |  |  |  |
|   |         |                  | IMMEDIATE CAUSE (a)                                      |                   |                     | DUE TO, OR AS A CONSEQUENCE OF                            |  |  |  |  |  |
|   |         |                  | (b)  |                   |                     | DUE TO, OR AS A CONSEQUENCE OF                            |  |  |  |  |  |
|   |         |                  | (c)  |                   |                     |   |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING        |         |                  | 21b. TIME OF INJURY                                      |                   |                     | 21c. HOW INJURY OCCURRED                                  |  |  | 22. I certify that I took charge of the remains described above, held on |  |  |
| OR CONTRIBUTING CAUSE OF DEATH            |         |                  | 8-23 P.M.  |                   |                     | subject shot  |  |  | Autopsy  |  |  |
| 21d. INJURY OCCURRED                      |         |                  | 21e. PLACE OF INJURY                                     |                   |                     | 21f. LOCATION   |  |  | Inspection   |  |  |
| WHILE AT WORK                             |         |                  | home   |                   |                     | 2805 Gatehouse Dr. Balto. City, Md.                       |  |  | Inquiry  |  |  |
| NOT WHILE AT WORK                         |         |                  |  |                   |                     |   |  |  | and in my opinion  |  |  |
|   |         |                  |  |                   |                     |   |  |  | death resulted from:   |  |  |
|   |         |                  |  |                   |                     |   |  |  | Natural causes   |  |  |
|   |         |                  |  |                   |                     |   |  |  | Accident   |  |  |
|   |         |                  |  |                   |                     |   |  |  | Suicide  |  |  |
|   |         |                  |  |                   |                     |   |  |  | Homicide   |  |  |
|   |         |                  |  |                   |                     |   |  |  | Undetermined manner  |  |  |
| ACTUAL SIGNATURE                          |         |                  | TITLE (SPECIFY)  |                   |                     | DATE SIGNED   |  |  |  |  |  |
| Hormez R. Guard, M.D.                     |         |                  | M.D. Assistant   |                   |                     | 1/27/83   |  |  |  |  |  |
| EXAMINER'S NAME                           |         |                  | ADDRESS  |                   |                     |   |  |  |  |  |  |
| (TYPE OR PRINT)                           |         |                  | 111 Penn St., Balto, Md. 21201                           |                   |                     |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL           |         |                  | 23b. DATE  |                   |                     | 23c. NAME OF CEMETERY OR CREMATORY                        |  |  | 23d. LOCATION  |  |  |
| BURIAL                                    |         |                  | 2/1/83   |                   |                     | MD Nat'l Mem PK   |  |  | Laurel   |  |  |
| 24. FUNERAL DIRECTOR                      |         |                  | 25a. DATE REC'D. BY REGISTRAR                            |                   |                     | 25b. REGISTRAR'S SIGNATURE                                |  |  |  |  |  |
| Jeff Miller                               |         |                  | 319 N. Schoroder St.                                     |                   |                     | JAN 31 1983   |  |  | John J. C. C.  |  |  |



JAN 31 1987 Glenview

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and a medical examination performed.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |   |   |  |  |   |
|--|--|--|--|---|---|---|--|--|---|
| 1- FOR<br>STATE<br>REGISTRAR   |  | REG. NO. <b>83 01283</b>   |  |   |   |   |  |  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARGARET M. PRESTIANNI</b>   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1.24.83</b> |   |  | 2b. HOUR<br><b>1145p</b> M   |   |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 12 39</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>43</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ohio</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY OF BALTO</b> MD.                                |  |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSP</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Registered Nurse</b>     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>St. Agnes Hospital</b>   |   |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Howard</b>   |  | 13c. CITY OR TOWN<br><b>Ellicott City</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>9334 Millbrook Road 21043</b>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Paul Kantzes</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Kathren Miskovitch</b>   |  |   |   |   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218-36-0609</b>   |  | 17. INFORMANT ADDRESS<br><b>Salvatore R. Prestianni 9334 Millbrook Rd. 21043</b>  |   |   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1749 IMMEDIATE CAUSE (a) METASTATIC CA BREAST</b>  |  |  |  |   |   |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |   |   |   |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |   |   |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1.03</b> 19 <b>83</b> to <b>1.24</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1.24</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death. |  |  |  |   |   |   |  |  |   |
| 22b. SIGNATURE<br><b>NAEEM A. SIDDIGI</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   |   |  | 22c. DATE SIGNED<br><b>1-24-83</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>NAEEM A. SIDDIGI</b>   |  |  |  | 22e. ADDRESS<br><b>ST. AGNES HOSP</b>   |   |   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/28/83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cem.</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                         |  |  |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 26 1983</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canfield</b>   |  |  |   |

1-2-10

CITY OF PHOENIX

ST. ANNE'S HOTEL

METASTATION

1-2-10

ST. ANNE'S HOTEL

ST. ANNE'S HOTEL

RECEIVED

COMMUNICATIONS SECTION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 3 0 1 2 8 4   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1 - FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT) <b>MR MICHAEL M. PRICE</b>   |  |   |  | 2a. DATE OF DEATH MONTH <b>1</b> DAY <b>14</b> YEAR <b>83</b> 2b. HOUR <b>12</b> MIN <b>17</b>  |  |  |  |
| 3 SEX <b>MALE</b>  |  | 4 RACE <b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH <b>FEBRUARY</b> DAY <b>28</b> YEAR <b>1906</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>BALTO., CITY</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE UNION MEMORIAL HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ELECTRICIAN</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>BUILDING</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>MARYLAND</b> 13b. COUNTY <b>BALTIMORE</b> 13c. CITY OR TOWN <b>BALTIMORE</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  | 13e. STREET ADDRESS <b>1122 E. 36th ST. 21218</b>   |  |  |  |
| 14 FATHER'S NAME FIRST <b>WILLIAM</b> MIDDLE <b>PRICE</b> LAST <b>PRICE</b>  |  |   |  | 15 MOTHER'S MAIDEN NAME FIRST <b>ROSE</b> MIDDLE <b>SHEVITZ</b> LAST <b>SHEVITZ</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b> (IF YES, GIVE WAR OR DATES)  |  |   |  | 16b. SOCIAL SECURITY NO. <b>214-20-4334</b>   |  | 17 INFORMANT ADDRESS <b>MRS. PAULINE PRICE 1122 E. 36th ST. 21218</b>  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:   |  |   |  |   |  |  |  |
| IMMEDIATE CAUSE (a) <b>RESPIRATORY DISTRESS, Cardio Respir</b>   |  |   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASPIRATION</b>   |  |   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b>INTRACEREBRAL BLEED</b>  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/15/83</b> 19 <b>83</b> , to <b>1/14</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1/13/83</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE <b>R. J. GIGGIO</b> DEGREE  |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>              |  | 22c. DATE SIGNED <b>1/14/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RIGGIO - JAGODA</b>   |  |   |  | 22e. ADDRESS <b>201 East University Parkway</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  | 23b. DATE <b>1/16/83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>BETH JACOB CEM.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>FINKSBURG CARROLL MARYLAND</b>  |  |
| 24 FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 18 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |
| 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215  |  |   |  |   |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 2 8 5

FOR  
1. STATE  
REGISTRAR

REG. NO.

|  |   |   |   |   |   |
|--|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Kenneth J Protani</b>   |   |   | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>17</b> YEAR <b>83</b>                      |   | 2b. HOUR<br><b>12:35 PM</b>   |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>W</b>   | 5. DATE OF BIRTH<br>MONTH <b>6</b> DAY <b>25</b> YEAR <b>21</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS.                                     |   | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY) <b>MF</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.                        |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University of Maryland Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Tilesetter</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Tile</b>  |   |
| 13a. STATE<br><b>Maryland</b>  |   | 13b. COUNTY<br><b>Anne Arundel</b>  | 13c. CITY OR TOWN<br><b>Pasadena</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>1006 Begarden La</b> <b>21122</b>   |
| 14. FATHER'S NAME<br>FIRST <b>unknown</b> MIDDLE <b></b> LAST <b></b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>unkn</b> MIDDLE <b></b> LAST <b></b>   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b> (IF YES, GIVE WAR OR DATES) <b>WWII</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>219-01-6423</b>  |   | 17. INFORMANT<br><b>Mrs. Joan Protani (Same as #13.)</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4860</b> IMMEDIATE CAUSE (a) <b>respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>hyperventilation syndrome</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>  |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>Eaton-Lambert syndrome, pneumonia</b>   |   |   |   |   |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/17</b> 19 <b>83</b> to <b>1/17</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1/17</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |   |   |   |
| 22b. SIGNATURE<br><b>C. Dimond</b>   |   | DEGREE  |   | 22c. DATE SIGNED<br><b>1/17/83</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. Dimond</b>  |   | 22e. ADDRESS<br><b>University of Maryland Hospital</b>  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Removal</b>  |   | 23b. DATE<br><b>1/19/83</b>   | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Anatomy Board</b>  |   | ADDRESS<br><b>Balto., Md.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 24 1983</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Calish</b>   |

BP

2000-0010101



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 167 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |         |                              |   |  |  |   |  |   |                                   |                            |          |          |  |  |
|--|---------|------------------------------|---|--|--|---|--|---|-----------------------------------|----------------------------|----------|----------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         |                              | FIRST MIDDLE LAST   |  |  | 2a. DATE KNOWN OF DEATH                                       |  |   | MONTH DAY YEAR                    |                            |          | 2b. HOUR |  |  |
| Darryl Wendell Pryor   |         |                              |   |  |  | 1-31 1983   |  |   |                                   |                            |          | M        |  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH             | 6. AGE (IN YEARS)   | IF UNDER 24 HRS.   |  | 7c. DATE PRONOUNCED DEAD                                      |  | MONTH DAY YEAR  |                                   |                            | 2d. HOUR |          |  |  |
| M  | Black   | 3 23 65                      | 17 YRS.   |  |  | 1-31 1983   |  |   |                                   |                            |          | a M      |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY? |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |   |                                   |                            |          |          |  |  |
| Virginia   |         | USA                          |   |  |  | Baltimore City MD.  |  |   |                                   |                            |          |          |  |  |
| 10. CITY OR TOWN OF DEATH  |         |                              | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |   | 12b. KIND OF BUSINESS OR INDUSTRY |                            |          |          |  |  |
| Baltimore  |         |                              | 1600 W. Baltimore Street  |  |  |   |  |   |                                   |                            |          |          |  |  |
| 13a. STATE   |         |                              |   | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |                                   | 13e. STREET ADDRESS        |          |          |  |  |
| Md   |         |                              |   |  |  | Balto.  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |                                   | 8 N. Stricker Street 21223 |          |          |  |  |
| 14. FATHER'S NAME  |         |                              |   | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |                                   |                            |          |          |  |  |
| John Lewis Pryor   |         |                              |   | Lillie King  |  |   |  |   |                                   |                            |          |          |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |         |                              |   | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS   |  |   |                                   |                            |          |          |  |  |
| No   |         |                              |   | 215 78 9517  |  | Lillie Pryor 8 N. Stricker Street                             |  |   |                                   |                            |          |          |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |                              |   |  |  |   |  |   |                                   |                            |          |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I DEATH WAS CAUSED BY:  |         |                              |   |  |  |   |  |   |                                   |                            |          |          |  |  |
| IMMEDIATE CAUSE (a) Gunshot wound of face  |         |                              |   |  |  |   |  |   |                                   |                            |          |          |  |  |
| 9654   |         |                              |   |  |  |   |  |   |                                   |                            |          |          |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  |         |                              |   |  |  |   |  |   |                                   |                            |          |          |  |  |
| (b)  |         |                              |   |  |  |   |  |   |                                   |                            |          |          |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |                              |   |  |  |   |  |   |                                   |                            |          |          |  |  |
| (c)  |         |                              |   |  |  |   |  |   |                                   |                            |          |          |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |         |                              |   |  |  |   |  |   |                                   |                            |          |          |  |  |
| 19a. DATE OF OPERATION   |         |                              |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  | 20. AUTOPSY?  |                                   |                            |          |          |  |  |
|  |         |                              |   |  |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |                                   |                            |          |          |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |                              |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                   |                            |          |          |  |  |
|  |         |                              |   | 12+ PM 1-31 1983   |  |   |  | Subject shot  |                                   |                            |          |          |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |         |                              |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION   |                                   |                            |          |          |  |  |
|  |         |                              |   | bar  |  |   |  | 1600 W. Baltimore St., Balto. Md.   |                                   |                            |          |          |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |                              |   |  |  |   |  |   |                                   |                            |          |          |  |  |
| ACTUAL SIGNATURE   |         |                              |   | TITLE (SPECIFY)  |  |   |  | DATE SIGNED   |                                   |                            |          |          |  |  |
| Thomas D. Smith  |         |                              |   | M. Deputy Chief  |  |   |  | 1-31-83   |                                   |                            |          |          |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |                              |   | ADDRESS  |  |   |  |   |                                   |                            |          |          |  |  |
| Thomas D. Smith, M.D.  |         |                              |   | III Penn Street, Baltimore, Md.  |  |   |  |   |                                   |                            |          |          |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         |                              |   | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY                            |  |   | 23d. LOCATION                     |                            |          |          |  |  |
| Burial   |         |                              |   | 2-5-83   |  | Jones Cemetery  |  |   | Kenbridge Virginia                |                            |          |          |  |  |
| 24. FUNERAL DIRECTOR NAME  |         |                              |   | ADDRESS  |  |   |  | 25a. DATE REC'D. BY REGISTRAR   |                                   |                            |          |          |  |  |
| Brown/Thompson F.H.  |         |                              |   | 1913 W. Baltimore St.  |  |   |  | FEB 3 1983 John J. Cabell   |                                   |                            |          |          |  |  |

RECEIVED  
FEB 2 1968

REPT NOTED

2/2

2/2







CO. 100th AIRBORNE DIV. (100th)

U.S.A.

100th AIRBORNE DIV.

100th AIRBORNE DIV.

100th AIRBORNE DIV.

100th AIRBORNE DIV.

100th AIRBORNE DIV.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 3 0 1 2 8 8  |  |                  |  |
|---|--|--|--|--|--|---|--|--|--|------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH  |  |   |  | 3b. HOUR   |  |                  |  |
| Ocey Pugh   |  |  |  | January 29, 1983   |  |   |  | M  |  |                  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS. |  |
| Male  |  | Black  |  | 8 MONTH 25 DAY 07 YEAR   |  | 75 YRS.   |  | MONTHS DAYS  |  | HOURS MIN.       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |                  |  |
| VA  |  | USA  |  |  |  | Baltimore City MD.  |  |  |  |                  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |                  |  |
| Baltimore   |  | 201 N. Broadway  |  |  |  |   |  |  |  |                  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |                  |  |
| MD  |  |  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 201 N. Broadway 21231  |  |                  |  |
| 14. FATHER'S NAME   |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |  |  |                  |  |
| Turner Pugh   |  |  |  | Alice  |  |   |  |  |  |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |  |  |                  |  |
| No  |  | 217-03-7301  |  | Ellen B. Pugh  |  | 201 N. Broadway   |  |  |  |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Esophageal Cancer</u><br>1509<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> |  |  |  |  |  |   |  |  |  |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |  |  |  |  |   |  |  |  |                  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                  |  |
|   |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |                  |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |  |  |  |                  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  |   |  |  |  |                  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9 27</u> , 19 <u>82</u> , to <u>12 3</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>12-3</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |  |  |                  |  |
| 22b. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED  |  |  |  |                  |  |
| <u>Stanley E. Oeder</u>   |  | MD   |  |  |  | <u>7/1/83</u>   |  |  |  |                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |   |  |  |  |                  |  |
| <u>Stanley E. Oeder MD</u>  |  | <u>Johns Hopkins</u>   |  |  |  |   |  |  |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | 23e. DATE REC'D. BY REGISTRAR                                  |  |                  |  |
| Burial  |  | 2/4/83   |  | Mt. Calvary Cem.   |  | Anne Arundel Co. MD   |  | FEB 1 1983   |  |                  |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |  |  |                  |  |
| Wm. C. March F/H 1101 E. North Ave.   |  | FEB 1 1983   |  | <u>John J. Conner</u>  |  |   |  |  |  |                  |  |



CHATELAIN

20% COTTON



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 3 0 1 2 8 9  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | CERTIFICATE OF DEATH   |  |  |  |
| I. DECEASED NAME   |  |  |  | 2a. DATE OF DEATH  |  |  |  |
| FIRST MIDDLE LAST  |  |  |  | MONTH DAY YEAR   |  |  |  |
| CHARLES C. PULSIFER JR.  |  |  |  | 1 9 83   |  |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  |
| Male   |  | White  |  | Dec. 13, 1930  |  | 52   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| New York   |  | U.S.A.   |  |  |  | BALTIMORE CITY   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| BALTIMORE  |  | VAMC, BALTIMORE, MD. 21218   |  | Accountant   |  | Computer   |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. INSIDE CITY LIMITS?   |  | 13d. STREET ADDRESS  |  |
| Maryland   |  | Baltimore  |  | 21234  |  | 2343 Foster Avenue 21234                                       |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |
| Charles C. Pulsifer, Sr.   |  |  |  | Elizabeth McClung  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT ADDRESS  |  |  |  |
| Yes  |  | Korea  |  | John K. Pulsifer 2911 Stockton Rd. 21131   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 4275 IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i>   |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |  |  |  |  |  |
| <i>Nasopharyngeal carcinoma</i>  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |  |  |
|  |  | P.M. 19  |  |  |  |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION  |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>NOVEMBER 26, 1982</u> , to <u>JANUARY 9, 1983</u> , that (I) (we) last saw the deceased alive on <u>JANUARY 9, 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| <i>Vincent E. H. Tam, MD</i>   |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 4/10/83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |  |  |
| <i>Vincent E. H. Tam, MD</i>   |  |  |  | 3900 LOCH RAVEN BLVD. BALTO., MD. 21218  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  |
| Cremation  |  | Jan. 11, '83   |  | Green Mount Cemetery Baltimore, Maryland   |  | CITY OR TOWN COUNTY STATE                                      |  |
| 24. FUNERAL DIRECTOR   |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |  |  |
| NAME ADDRESS   |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
| William E. Johnson 8521 Loch Raven Blvd.   |  |  |  | JAN 10 1983 <i>John J. Tamm</i>  |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 3 0 1 2 9 0  
CERTIFICATE OF DEATH

FOR  
1- STATE  
REGISTRAR

REG. NO.

|  |   |   |  |   |  |
|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>AMELTA M RABIN  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JANUARY 29 1983                         |   | 2b. HOUR<br>04:10 AM   |
| 3. SEX<br>FEMALE   | 4. RACE<br>WHITE  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 17 1912  | 6. AGE<br>IN YEARS (LAST BIRTHDAY)<br>70 YRS.                                  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>MARYLAND   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                     |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SEAMSTRESS |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>CLOTHING WKR  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD   |   | 13b. COUNTY<br>BALTO  | 13c. CITY OR TOWN<br>BALTO   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>226 S CHESTER ST 21231  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>FRANK OSTROVSKI  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MAGDALENA WALEGA   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                      |  |
| 16b. SOCIAL SECURITY NO.<br>212-07-6393  |   | 17. INFORMANT<br>HARRY C. PAESCH  |  | ADDRESS<br>451 ROYAL BEACH ROAD ANNAPOLIS   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1: DEATH WAS CAUSED BY:<br>5188 IMMEDIATE CAUSE (a) Cardiac Arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) Sepsis<br>(c) Pulmonary Embolus |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)<br>Endometrial Carcinoma  |   |   |  |   |  |
| 19a. DATE OF OPERATION<br>1/18/83  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Pul insufficiency   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-29-82, to 1-29-83, that (I) (we) last saw the deceased alive on 1-29-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                        |   |   |  |   |  |
| 22b. SIGNATURE<br>William C Dooley MD  |   | DEGREE<br>MD  |  | 22c. DATES SIGNED<br>1/29/83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>William C Dooley MD   |   | 22e. ADDRESS<br>Johns Hopkins Hospital  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   | 23b. DATE<br>2-1-83   | 23c. NAME OF CEMETERY OR CREMATORY<br>SACRED HEART OF JESUS   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO MD  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>John M. Weber & Sons Inc   |   | ADDRESS<br>401 S. CHESTER ST  |  | 25. DATE REC'D. BY REGISTRAR<br>FEB 2 1983  |  |
|  |   |   |  | 25. REGISTRAR'S SIGNATURE<br>John J. Carver   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner may be notified by letter.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |   | 8 3 0 1 2 9 1   |  |
|--|--|---|---|---|--|
| 1. FOR STATE REGISTRAR   |  |   |   | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Aleksas Raguckas</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 20 83</b> |   | 2b. HOUR<br><b>5.55 AM</b>                   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>                          | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 15 14</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS<br>IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Lithuania</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Lithuania</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>St Agnes Hospital</b>   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired Tailor</b>                      |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>                 | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Augustinas Raguckas</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br><b>Petronele Rinkevicius</b>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>129-26-9111</b>  |   | 17. INFORMANT ADDRESS<br><b>Mrs Angela Raguckas Same</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardio respiratory arrest</b><br><b>4360</b> DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cerebrovascular accident</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>hypertension</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>   |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-22-82</b> , 19 <b>82</b> , to <b>1-20</b> , 19 <b>83</b> , that (I) (we) lost<br>saw the deceased alive on <b>1-19</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |
| 22b. SIGNATURE<br><b>Qui Dien Huynh</b>  |  |   |   | 22c. DATE SIGNED<br><b>1-20-83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>QUI DIEN HUYNH</b>   |  |   |   | 22e. ADDRESS  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/24/83</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 21 1983</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John J. Gault</b>   |  |   |   |   |  |





THE UNIVERSITY OF CHICAGO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 8 3 0 1 2 9 2  |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Frederick M. Rahn</b>  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 9 83</b>               |   |  | 2b. HOUR<br><b>8:30 AM</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 07 14</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b>  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Indiana</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore, MD</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired Chemical</b>     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Engineer</b>   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Lochearn</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3634 Lochearn Dr. 21207</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frederick W. Rahn</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anne McCoy</b> |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>355-07-4409</b>  |  | 17. INFORMANT<br><b>Baltimore, MD</b>   |  | ADDRESS<br><b>21207</b>   |  | Ethel Rahn 3634 Lochearn Dr.   |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Uremia</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>Chronic Renal Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Deborah Ward</b>   |  |  |  | DEGREE<br><b>MD</b>   |  |   |  | 22c. DATE SIGNED<br><b>1/9/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Deborah Ward</b>  |  |  |  | 22e. ADDRESS<br><b>Sinai Hospital of Baltimore</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1-12-83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lake View Memorial Pk</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Eldersburg Carroll MD</b>                      |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Loring Byers Funeral Directors, Inc</b><br><b>8728 Liberty Rd. Randallstown, Md 21133</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 11 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 2 9 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |   |  |   |
|--|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>WILLIAM R. RANDALL  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 26 83  |  | 2b. HOUR<br>11:30A  |
| 3. SEX<br>MALE   | 4. RACE<br>BLACK  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 27 26  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>56 YRS.  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD                                       |  |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VAMC LOCH RAVEN BLVD. BALTO MD |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Disabled Veteran            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                 |
| 13a. STATE<br>MD   |   | 13b. COUNTY<br>Baltimore  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS<br>4108 Maine Avenue Z1207                                 |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Randall  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth Cross  |   | 16. ADDRESS<br>740 S. Woodington Rd<br>Baltimore, Md 21229                     |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, GIVE WAR OR DATES)<br>Yes WWII; Korea  |   | 16b. SOCIAL SECURITY NO.<br>219 20 9282   |   | 17. INFORMANT<br>Annette Thomas  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>+278 IMMEDIATE CAUSE (a) <u>Bradycardia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Respiratory Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Unknown</u> |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>Nausea + Vomiting</u>   |   |   |   |  |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |   |   |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>December 28, 1982</u> to <u>January 26, 1983</u> , that (X) (we) last saw the deceased alive on <u>January 26, 1983</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did not view the body after death.                                      |   |   |   |  |   |
| 22b. SIGNATURE<br><u>Herbert E. Nutter</u>   |   | DEGREE<br>MD  |   | 22c. DATE SIGNED   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MAURER MD   |   | 22e. ADDRESS<br>3900 Loch Raven Blvd. Baltimore, Md 21218   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |   | 23b. DATE<br>1/26/83  | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. Vets. Ceme.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Anne Arundel Co. MD |
| 24. FUNERAL DIRECTOR<br>NAME<br>HERBERT E. NUTTER- 3035 W. NORTH AVE.  |   | ADDRESS<br>3035 W. NORTH AVE.   |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 28 1983                                   |   |
|  |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Smith</u>                             |   |



CHIEF IN CHARGE



20% COORD. FILE

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 2 9 4

1. FOR  
STATE  
REGISTRAR

REG. NO.

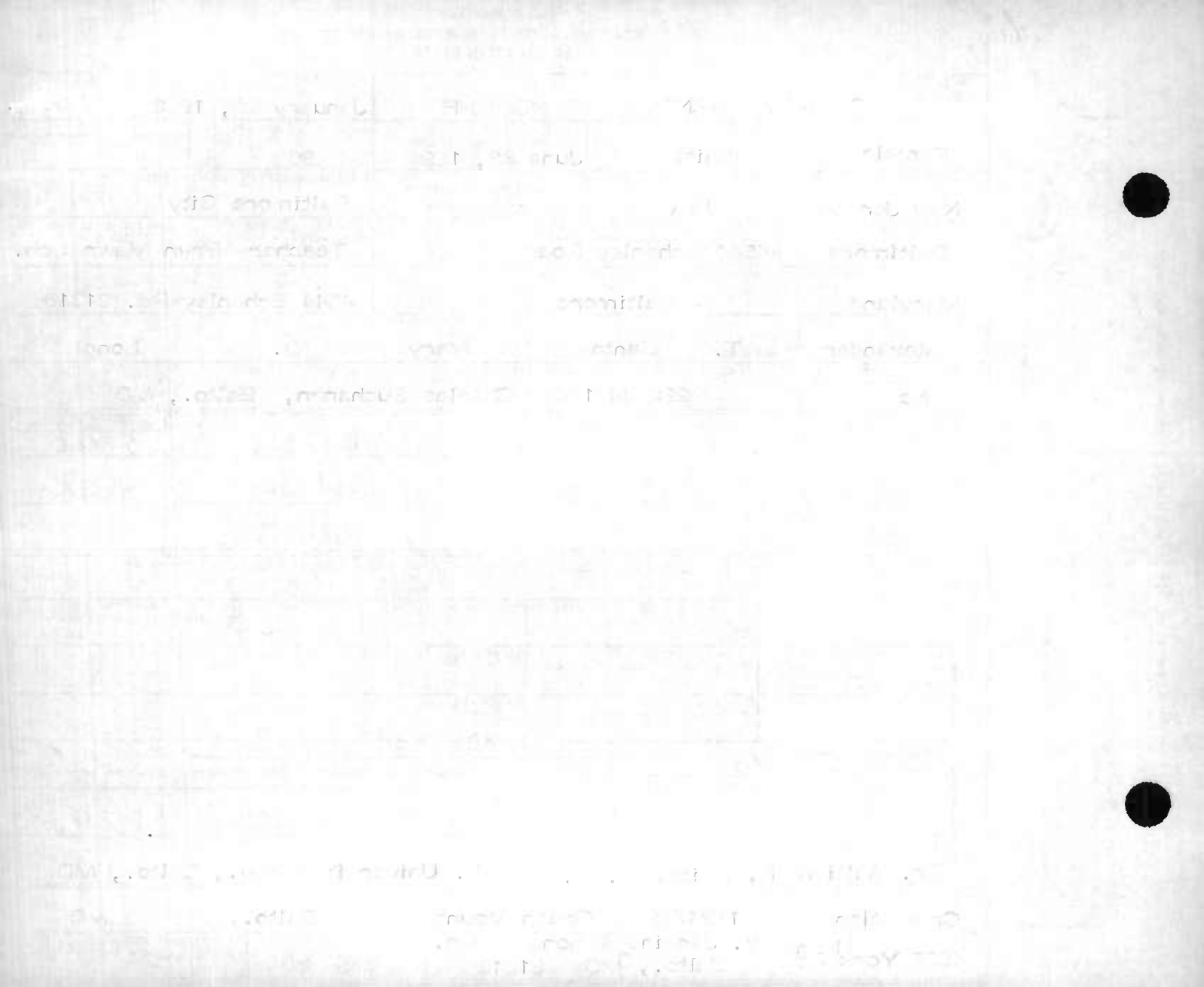
|  |  |  |  |   |  |  |   |  |   |  |
|--|--|--|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CARMEN SANTOS RANDOLPH</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>January 23, 1983</b>            |   |  | 2b. HOUR<br><b>5:00 p.m.</b>   |   |  |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>June 23, 1894</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New Jersey</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4544 Schenley Road</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Teacher- Bryn Mawr Sch.</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>                    |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>4544 Schenley Rd. 21210</b> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Alexander T. Santos</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary O. Long</b>   |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>220 44 1868</b>                         |   |  | 17. INFORMANT ADDRESS<br><b>Charles Buchanan, Balto., MD</b>                                       |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY.<br><b>4140</b> IMMEDIATE CAUSE (a) <b>reticular fibrillation</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>chronic heart disease</b><br>(c) <b>4 years</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 min</b> |  |  |  |   |  |  |   | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)        |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                     |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>Jan 13</b> 19 <b>69</b> to <b>1/23</b> 19 <b>83</b> , that (I) (the) lost saw the deceased alive on <b>Nov. 9</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.   |  |  |  |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>William F. Fritz</b> DEGREE <b>MD</b>   |  |  |  |   |  | 22c. DATE SIGNED<br><b>1/24/83</b>   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. William F. Fritz, M. D.</b>  |  |  |  |   |  | 22e. ADDRESS<br><b>2 W. University Pkwy., Balto., MD</b>   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  |  | 23b. DATE<br><b>1/24/83</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., MD</b>                                 |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Henry W. Jenkins &amp; Sons Co.</b><br><b>4905 York Road Balto., MD 21212</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 25 1983</b>  |   |  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John J. Smith</b>   |  |  |  |   |  |  |   |  |   |  |

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BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 2 9 5

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |   |  |  |  |  |  |                     |  |   |  |
|---|--|--|--|---|--|---|--|--|--|--|--|---------------------|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>Michael   |  | MIDDLE<br>Paul  |  | LAST<br>Ravenis   |  | 26. DATE OF DEATH<br>MONTH<br>1/14/83  |  | DAY<br>10                              |  | YEAR<br>35          |  | 26. HOUR<br>AM                                    |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH<br>9 - DAY<br>7 - YEAR<br>62  |  | 6. AGE<br>(IN YEARS LAST BIRTHDAY)<br>20  |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS  |  | IF UNDER 24 HRS<br>HOURS<br>MIN.       |  |                     |  |   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Wash., D.C.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                       |  |  |  |  |  |                     |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Student                     |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>- |  |                     |  |   |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>1321 Rosewick Ave.  |  |  |  |                     |  | 21237   |  |
| 14. FATHER'S NAME<br>FIRST<br>Vincent   |  |  |  | MIDDLE<br>J.  |  | LAST<br>Ravenis   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>Rosemarie   |  |  |  | MIDDLE<br>Fioriglio |  | LAST  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>219-90-9648   |  | 17. INFORMANT<br>ADDRESS<br>same address<br>Vincent Ravenis (father)  |  |   |  |  |  |  |  |                     |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u><br>2050<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>unknown</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 Hour |  |  |  |   |  |   |  |  |  |  |  |                     |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>A M M o L, Herpes Cellulitis, Candida Esophagitis, Interferon Therapy</u>  |  |  |  |   |  |   |  |  |  |  |  |                     |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |                     |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |  |  |  |                     |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |                     |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/12/82</u> to <u>1/14/82</u> , that (I) (we) lost saw the deceased alive on <u>1/14/82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |  |  |                     |  |   |  |
| 22b. SIGNATURE<br><u>David Patz</u>   |  | DEGREE<br><u>MD</u>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><u>1/14/82</u>  |  |  |  |  |  |                     |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>DAVID</u>   |  | PATZ   |  | 22e. ADDRESS<br><u>UNIVERSITY HOSP. BALTO. MD.</u>  |  |   |  |  |  |  |  |                     |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>1/17/83   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer   |  | 23d. LOCATION<br>CITY OR TOWN<br>Balto.   |  | COUNTY<br>Md.  |  | STATE                                  |  |                     |  |   |  |
| 24. FUNERAL DIRECTOR<br>Schimunek Funeral Home, Inc.<br>3331 Brehms Lane, Balto. Md. 21213  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 18 1983   |  |   |  |   |  |  |  |  |  |                     |  | 25b. REGISTRAR'S SIGNATURE<br><u>J. J. Cahill</u> |  |



RECEIVED  
JAN 11 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 2 9 6

REG. NO.

|  |  |  |  |   |   |   |   |  |  |
|--|--|--|--|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>BEVERLY J. RECKARD</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 22 83</b>                  |   |   | 2b. HOUR<br><b>6 41 PM</b>  |   |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 24 50</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>32</b>  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 8b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 9. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University of Maryland</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>---</b>                  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>---</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>320 S. Woodyear Street 21223</b>   |  |
| 14. FATHER'S NAME<br>MIDDLE LAST<br><b>Edward Reckard, Sr.</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emma Mosmiller</b> |   |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>NONE</b>   |  | 17. INFORMANT ADDRESS<br><b>Anne E. Reckard 8382 Elm Road 21108</b>   |   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>3181</b> IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic Aspiration Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Severe Mental Retardation</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>32 yrs</b> |  |  |  |   |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |  |   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/22</b> , 19 <b>83</b> , to <b>1/22</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>at arrived 02A</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                  |  |  |  |   |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Lawrence Goldkind MD</b>  |  |  |  |   |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>1/22/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Lawrence Goldkind</b>  |  |  |  |   |   | 22e. ADDRESS<br><b>22 S. Greene St. Baltimore Md.</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>1/26/83</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Mem. Pk.</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Elkridge Howard Maryland</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.</b>  |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 24 1983</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>  |  |

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COTTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a copy of the report filed with this certificate.

| FOR STATE REGISTRAR  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  | 8 3 0 1 2 9 7   |  |
|--|--|---|--|---|--|
| REGISTRAR Edward L RECKARD Sr  |  | CERTIFICATE OF DEATH  |  | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST<br>Edward L Beckard Sr  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>1-14-83 1-14-83   |  |
| 3. SEX<br>M  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Aug 12 1915  |  |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore, Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Bon Secours Hospital |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Worker   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Wards delivery   |  |   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>---  |  | 13c. CITY OR TOWN<br>Baltimore  |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>320 S. Woodyear St. 21223  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Reckard   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anne Houck   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW-II  |  | 17. INFORMANT ADDRESS<br>21223<br>Emma M Reckard/320 S Woodyear St/Balto Md   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) <u>CARDIO pulmonary Arrest</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Congenital heart Failure</u><br>(c) <u>ASCVD -</u>                                 |  | DUE TO, OR AS A CONSEQUENCE OF  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>minutes</u><br><u>days</u><br><u>years</u>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/11</u> , 19 <u>83</u> , to <u>1-14</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>1/14</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |
| 22b. SIGNATURE<br><u>[Signature]</u>   |  | DEGREE<br><u>MD</u>   |  | 22c. DATE SIGNED<br><u>1/14/83</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>NANCY P. ACQUETRE   |  | 22e. ADDRESS<br>1940 W Balto St Balto, Md 21223   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>01/18/83   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem. Park   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Elkridge/Howard/Md 21227   |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Walters Funeral Home/Pratt & Stricker Streets  |  | ADDRESS<br>Balto Md 21223   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 17 1983  |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |

RECEIVED  
JAN 10 1964  
U.S. AIR FORCE

OFFICE OF THE  
JOINT CHIEFS OF STAFF  
WASHINGTON, D.C.

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*[Faint, mostly illegible handwritten text and markings, possibly including a signature and various notations.]*

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |   |  |   |  |                         |  |                                      |  |        |  |          |  |      |  |          |  |
|---|--|--|--|---|--|---|--|---|--|-------------------------|--|--------------------------------------|--|--------|--|----------|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST  |  | MIDDLE  |  | LAST  |  | 7a. DATE KNOWN OF DEATH   |  | MONTH                   |  | DAY                                  |  | YEAR   |  | 7b. HOUR |  |      |  |          |  |
| CHARLES   |  | WILLIAM  |  | REED  |  |   |  | 1-30-83   |  | 19                      |  |                                      |  |        |  |          |  |      |  |          |  |
| 1. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.        |  | 7c. DATE PRONOUNCED DEAD             |  | MONTH  |  | DAY      |  | YEAR |  | 7d. HOUR |  |
| Male  |  | White  |  | 4-14-1938   |  | 44 YRS.   |  |   |  |                         |  | 1-30-83                              |  | 19     |  |          |  |      |  | 5:21A    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED  |  | NEVER MARRIED   |  | WIDOWED   |  | DIVORCED                |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |        |  |          |  |      |  |          |  |
| Virginia  |  | U.S.A.   |  |   |  |   |  |   |  |                         |  | BALTIMORE CITY                       |  |        |  |          |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |                         |  |                                      |  |        |  |          |  |      |  |          |  |
| Baltimore   |  | 1036 Quantril Way  |  | Forklift Operator   |  | Nat'l Gypsum  |  |   |  |                         |  |                                      |  |        |  |          |  |      |  |          |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13a. STATE   |  | 13b. CITY OR TOWN   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS     |  |                                      |  |        |  |          |  |      |  |          |  |
| Md.   |  | -  |  | Baltimore   |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1036 Quantril Way 21205 |  |                                      |  |        |  |          |  |      |  |          |  |
| 14. FATHER'S NAME   |  | FIRST  |  | MIDDLE  |  | LAST  |  | 15. MOTHER'S MAIDEN NAME  |  | FIRST                   |  | MIDDLE                               |  | LAST   |  |          |  |      |  |          |  |
| William   |  |  |  |   |  | Reed  |  | Lucy  |  |                         |  |                                      |  | McVey  |  |          |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |   |  |                         |  |                                      |  |        |  |          |  |      |  |          |  |
| yes   |  | 1957   |  | 230-46-5240   |  | Marie Reed (wife) same address  |  |   |  |                         |  |                                      |  |        |  |          |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | PART I DEATH WAS CAUSED BY:  |  | IMMEDIATE CAUSE (a)   |  | Hypertensive arteriosclerotic cardiovascular                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |                         |  |                                      |  |        |  |          |  |      |  |          |  |
| 4029  |  |  |  |   |  | disease   |  |   |  |                         |  |                                      |  |        |  |          |  |      |  |          |  |
|   |  |  |  |   |  | DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |                         |  |                                      |  |        |  |          |  |      |  |          |  |
|   |  |  |  |   |  | (c)   |  |   |  |                         |  |                                      |  |        |  |          |  |      |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  |  |  |   |  |   |  |   |  |                         |  |                                      |  |        |  |          |  |      |  |          |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?  |  |   |  |   |  |                         |  |                                      |  |        |  |          |  |      |  |          |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |   |  |                         |  |                                      |  |        |  |          |  |      |  |          |  |
| 21a. EXTERNAL CAUSE WAS   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED  |  | 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY  |  | 21f. LOCATION           |  |                                      |  |        |  |          |  |      |  |          |  |
| UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | HOUR A.M. MONTH DAY YEAR   |  | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2                  |  | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | STREET, FACTORY, FARM, ETC.)  |  | STREET                  |  | CITY OR TOWN                         |  | COUNTY |  | STATE    |  |      |  |          |  |
|   |  | P.M. 19  |  |   |  |   |  |   |  |                         |  |                                      |  |        |  |          |  |      |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on   |  | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion   |  |   |  |   |  |   |  |                         |  |                                      |  |        |  |          |  |      |  |          |  |
| death resulted from:  |  | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |   |  |   |  |                         |  |                                      |  |        |  |          |  |      |  |          |  |
| ACTUAL SIGNATURE  |  | TITLE (SPECIFY)  |  | DATE SIGNED   |  |   |  |   |  |                         |  |                                      |  |        |  |          |  |      |  |          |  |
| Margarita A. Korell, M.D.   |  | M.D. Assistant   |  | 1-30-83   |  |   |  |   |  |                         |  |                                      |  |        |  |          |  |      |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  | ADDRESS  |  |   |  |   |  |   |  |                         |  |                                      |  |        |  |          |  |      |  |          |  |
| 123a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY                                  |  | 23d. LOCATION   |  |   |  |                         |  |                                      |  |        |  |          |  |      |  |          |  |
| Burial  |  | 2/2/83   |  | Crownsville Veteran   |  | Crownsville, Md.  |  |   |  |                         |  |                                      |  |        |  |          |  |      |  |          |  |
| 24. FUNERAL HOME, INC.  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |   |  |                         |  |                                      |  |        |  |          |  |      |  |          |  |
| 3331 Brehms Lane, Balto. Md. 21213  |  | FEB 1 1983   |  | John J. Gierke  |  |   |  |   |  |                         |  |                                      |  |        |  |          |  |      |  |          |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201





June 1, 1933  
J. G. Smith

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189 89 46  
DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Regis. Ronald

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Regis. may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove attachments papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 2 9 9

1- STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |   |
|--|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>RONALD George REGI</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>01/20/83</b>                                |   | 2b. HOUR<br><b>5:30PM</b>                                 |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>white</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 23 1945</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>37</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PA</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD                                |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>1st Lt.</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>military</b>      |
| 13a. STATE<br><b>PA</b>  |  | 13b. COUNTY<br><b>Franklin</b>  | 13c. CITY OR TOWN<br><b>Chambersburg</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Norris Regi</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Erma K. Flasher</b>   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>1963-1976</b>  |  | 17. INFORMANT ADDRESS<br><b>Virginia Regi, 3820 Lisbon Dr. Chambersburg,</b>                    |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>septic shock</b><br><b>2050</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Aspergillus infection</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Acute Myelocytic Leukemia</b> |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>PA</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/6</b> , 19 <b>82</b> , to <b>1/20</b> , 19 <b>83</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/20</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |   |
| 22b. SIGNATURE<br><b>J. Niles</b>  |  | DEGREE<br><b>Attending Physician</b>  |  | 22c. DATE SIGNED<br><b>1/20/83</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. Niles</b>   |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>burial</b>  | 23b. DATE<br><b>1-24-83</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Indiantown Gap Nat. Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Indiantown Gap, Lebanon Co., PA</b>            |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Eline Funeral Home</b>  |  | ADDRESS<br><b>Reisterstown, Md.</b>   |  | 25a. DATE REC'D BY REGISTRAR<br><b>JAN 27 1983</b>  |   |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b> PA  |   |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MATTHEW RETZKER</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1 29 83</b> |   |  | 2b. HOUR<br><b>8:45 PM</b>   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>12 12 1897</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW YORK</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LEVINDALE</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MFG. REP.</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HARDWARE/GARDEN</b>  |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. CITY OR TOWN<br><b>TOWSON</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS<br><b>8415 BELLONA LANE APT 208</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MICHAEL RETZKER</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>DORA GOLDBERG</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>085-09-5430</b>   |  |
| 17. INFORMANT<br><b>MRS. LILLIAN D. RETZKER</b>  |  | 17. ADDRESS<br><b>8415 BELLONA LANE TOWSON, MD 21204</b>  |  | 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cancer Pancreas</b><br>1579<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 months</b> |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <b>8:40pm 1/29/1983</b> to <b>1/6/1983</b> , that (b) (we) lost <b>1/29/1983</b> , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above, and that (d) (we) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>   |  | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  | 22c. DATE SIGNED<br><b>1/29/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KHIN M. TUN</b>  |  | 22e. ADDRESS<br><b>2110 Pot Spring Road Md 21093</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>CREMATION</b>   |  | 23b. DATE<br><b>JAN. 31, 1983</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b><br>ADDRESS<br><b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 1 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 3 0 1

REG. NO.

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Otto M. Reuter  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Jan. 2 83<br>2b. HOUR<br>M  |  |  |
| 3. SEX<br>Male  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 23 1916   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospital's |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Crane Operator   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Beth. Steel                               |  |
| 13a. STATE<br>Maryland  |  |   | 13b. COUNTY<br>Baltimore   | 13c. CITY OR TOWN<br>Dundalk   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Henry Reuter  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lolna Phoetner  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>212-07-5553   | 17. INFORMANT<br>ADDRESS<br>Irma L. Reuter 1906 Kelmores Road<br>Balto., MD. 21222   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>2500 IMMEDIATE CAUSE (a) <u>Myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <u>ASCVD</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(c) <u>Diabetes mellitus</u>        |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 Hrs<br>10 MRS<br>10 YRS  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/14</u> , 19 <u>74</u> , to <u>1-2</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>9/11</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |
| 22b. SIGNATURE<br><u>John V. Conway</u>   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John V. Conway, MD.  |  |   | 22e. ADDRESS<br>3401 Dundalk Ave., Balt. Md. 21222   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>1/6/1983  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens Of Faith  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Duda-Ruck Funeral Home of Dundalk, Inc.   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 5 1983  |  |  |
|   |  |   | 25b. REGISTRAR'S SIGNATURE<br><u>John V. Conway</u>  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |  |  |   |  | 8 3 0 1 3 0 2  |  |
|---|--|--|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   |  |  |  |   |  | CERTIFICATE OF DEATH   |  |
| REG. NO.  |  |  |  |   |  |  |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SAMUEL L. REYNOLDS, Sr.</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>17</b> YEAR <b>83</b>                   |  | 2b. HOUR<br><b>M</b>  |  |  |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>2</b> YEAR <b>19</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.                                  |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                            |  | IF UNDER 24 HRS<br>HOURS <b></b> MIN. <b></b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.                     |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2915 Grantley Ave.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-0-</b>                           |  |  |  |
| 13a. STATE<br><b>Md.</b>  |  |  |  |   |  | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST <b>John</b> MIDDLE <b>Ferguson</b> LAST <b>Reynolds</b>  |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Lillian</b> MIDDLE <b>Davis</b> LAST <b></b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II (UNKNOWN)</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>231-07-2057</b>  |  | 17. INFORMANT ADDRESS<br><b>Samuel L Reynolds, Jr 2915 Grantley Ave.</b>           |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4960</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Diffuse Interstitial Pulmonary Fibrosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Severe Chronic Obstructive Lung Disease</b> |  |  |  |   |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Hypertension; 90/110</b>  |  |  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>9/9</b>  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR <b></b> A.M. <b></b> MONTH <b></b> DAY <b></b> YEAR <b>19</b><br><b>P.M.</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)     |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>LUCIA E. CAUETE M.D.</b>   |  |  |  |   |  | DEGREE <b></b>   |  | 22c. DATE SIGNED<br><b>1/20/83</b>  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LUCIA E. CAUETE M.D.</b>   |  |
| 22e. ADDRESS<br><b>3100 Wyman Park Drive Balto. MD</b>  |  |  |  |   |  | 22f. ADDRESS<br><b></b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  |  |  | 23b. DATE<br><b>1/22/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem Park</b>                      |  | 23d. LOCATION<br><b>Baltimore, MD</b> STATE <b></b>                       |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Law Funeral Home</b> ADDRESS <b>4611 Park Heights Ave.</b>  |  |  |  |   |  | 25a. DATE REG. BY REGISTRAR'S SIGNATURE<br><b>JAN 24 1983</b>                      |  |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |  |  |  |   |  |   |   |
|--|--|---|--|--|--|--|---|--|---|---|
| CERTIFICATE OF DEATH   |  |   |  |  |  |  |   |  |   |   |
| REG. NO.   |  |   |  |  | REG. NO.   |  |   |  |   |   |
| 1. DECEASED NAME<br>(Last, first, middle)<br><b>Fred N Rhodes</b>  |  |   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 28 83</b>  |  |   |  |   | 2b. HOUR<br><b>2:09</b> P.M.                    |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 18 07</b>   |  | 6. AGE (IN YEARS LAST MONTH DAY)<br><b>7.6</b> YRS.                                |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>7.6</b>  |   | 8. IF UNDER 24 HRS<br>HOURS MIN.<br><b>2:09</b> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N. Carolina</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balt City Hospital E.R.</b> MD.         |   |  |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospital</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Bethlehem Steel</b>  |   |   |
| 13a. STATE<br><b>Md.</b>   |  |   |  |  | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Lonnie Rhodes</b>   |  |   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lahla Brown</b>  |  |   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  |   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br><b>Navy WWII 212-18-9014</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Vivian Rose Rhodes - 918 Quantril Way 21205</b> |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardio pulmonary Arrest</b><br>4149<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Coronary Artery Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Viral Syndrome Flu-like</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |  |  |  |   |  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Frequent Premature Contractions treated with Norpace</b>  |  |   |  |  |  |  |   |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/24 19 83</b> to <b>1/28 83</b> , that (I) (we) last saw the deceased alive on <b>1/24 19 83</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                       |  |   |  |  |  |  |   |  |   |   |
| 22b. SIGNATURE<br><b>Hal Cook MD</b>   |  |   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   | 22c. DATE SIGNED<br><b>1/28/83</b>   |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Hal Cook</b>   |  |   |  |  | 22e. ADDRESS<br><b>Baltimore City Hospitals</b>  |  |   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>2-1-83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>                    |   |  |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John C. Miller Inc-6415 Belair Rd.-21206</b>  |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 31 1983</b>                                |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Gairish</b>   |   |   |



CONFIDENTIAL  
JAN 31 1983

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |   | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  | 8 3 0 1 3 0 4  |   |
|---|---|---|--|--|---|
| I. DECEASED NAME<br>(TYPE OR PRINT)   |   | FIRST   | MIDDLE   | LAST   | REG. NO.  |
| WILLIAM A. RHOTON   |   |   |  |  |   |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |   |
| Male  | Cauc.   | 6/12/18   |  | 64   |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |
| Va.   | U.S.  |   |  | BALTIMORE, City MD.  |   |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY               |
| BALTIMORE   | VAMC BALTIMORE, MARYLAND 21218  |   | Retired  |  |   |
| 13a. STATE  |   | 13b. CITY OR TOWN   | 13c. INSIDE CITY LIMITS?   | 13d. STREET ADDRESS  |   |
| Md.   | Balto.  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 3032 Keswick Rd. 21211   |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |  |   |
| ?   |   | ?   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |   |
| Yes   |   | 226 18 6650   |  | Kathlene Rhoton same   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4289 IMMEDIATE CAUSE (a) Cardiac arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Heart failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Respiratory failure  |   |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>Pneumonia and possibly lung cancer  |   |   |  |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (this hospital) attended the deceased from SEPTEMBER 20, 19 82, to January 5, 19 83, that (we) lost<br>saw the deceased alive on January 5, 19 83, and that in (our) opinion death occurred on the date and hour and from the causes stated<br>above, (we) (did) (did not) view the body after death. |   |   |  |  |   |
| 22b. SIGNATURE<br>T B Tupper MD   |   |   |  | 22c. DATE SIGNED   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>T B Tupper MD  |   |   |  | 22e. ADDRESS<br>3900 Loch Raven Blvd. Balto. Md 21218                                |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |   | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE      |
| Burial  |   | 1/8/83  | Hurds Cemetery   |  | Gate City, Va.                                  |
| 24. FUNERAL DIRECTOR<br>NAME  |   |   |  | 25a. DATE REC'D. BY REGISTRAR  |   |
| Paul E. Chenoweth 3rd. 3617 Chestnut Ave.   |   |   |  | JAN 13 1983  |   |
|   |   |   |  | REGISTRAR'S SIGNATURE<br>John J. Conner  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  | 8 3 0 1 3 0 5   |  |
|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MARGARET RICE</b>   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1 1 31 83</b> 2b. HOUR<br><b>11:30a</b>                            |  |
| 3. SEX<br><b>F</b> Female   | 4. RACE<br><b>Caucasian</b>  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>11 19 08</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Canada</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Canadaian</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samaritan Hospital</b>                          | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO CITY</b> MD  |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   | 13b. CITY OR TOWN<br><b>Prince George Bethesda</b>   | 12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary</b>                         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>John W. Carson</b>  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Annie Mackenzie</b>   | 13c. STREET ADDRESS<br><b>20817 8005 Carita Court</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES<br><b>No</b>  | 16b. SOCIAL SECURITY NO.<br><b>---</b>   | 17. INFORMANT ADDRESS<br><b>Dr. Frederick Rice Bethesda, Maryland</b>                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br><b>1991</b> IMMEDIATE CAUSE (a) <b>Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>metastatic adenocarcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>---</b>  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a   |  |   |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                            |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>January 5, 19 83</b> , to <b>January 31, 19 83</b> , that (I) (we) lost saw the deceased alive on <b>JANUARY 31, 19 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |
| 22b. SIGNATURE<br><b>Mary M. Newman</b>   | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br><b>1-31-83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARY M NEWMAN</b>   | 22e. ADDRESS<br><b>GOOD SAMARITAN HOSPITAL</b>   |   |  |
| 23b. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>2-4-83</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Haliburton Cemetery</b>  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Pictou, Nova Scotia, Canada</b>  |
| 24. FUNERAL DIRECTOR NAME<br><b>Marzullo Funeral Service</b>  | 25a. DATE REC'D. BY REGISTRAR (25b. REGISTRAR'S SIGNATURE)<br><b>FEB 4 1983 John J. Carver</b>   |   |  |





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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 3 0 1 3 0 6  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1 - FOR STATE REGISTRAR  |  |   |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Lucy K. Richards (Reed)</i>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>January 1, 1983</i>   |  | 2b. HOUR P. M.<br><i>8:30 P.</i>  |  |
| 3 SEX<br><i>Female</i>   |  | 4 RACE<br><i>White</i>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>7 11 10</i>  |  | 6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br><i>72</i>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Pennsylvania</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.  |  |
| 10 CITY OR TOWN OF DEATH<br><i>Baltimore</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Johns Hopkins Hospital</i> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housework</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>At Home</i>   |  |
| 13a. STATE<br><i>Maryland</i>  |  |   |  | 13b. COUNTY<br><i>Baltimore</i>  |  | 13c. CITY OR TOWN<br><i>Baltimore</i>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Gregory Kolar</i>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Anna Krehel</i>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>No</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>181-12-2398</i>  |  | 17 INFORMANT ADDRESS<br><i>Henry B. Reed 519 S. Duncan Street 21231</i>  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Coronary Stenosis</i><br><i>4100</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Unstable Angina Scabrous</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19. PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/15</i> 19 <i>82</i> , to <i>12/15</i> 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>12/15</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Julius H. Goodman</i>   |  | DEGREE<br><i>M.D.</i>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  | 22c. DATE SIGNED<br><i>12/3/83</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Julius H. Goodman</i>  |  | 22e. ADDRESS<br><i>254 S. E. St. NW 21202</i>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>1-4-83</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Sacred Heart Cemetery</i>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Dundalk Baltimore Co. Md.</i>   |  |
| 24. FUNERAL DIRECTOR NAME<br><i>C.S. Zeiler &amp; Son Inc.</i>   |  |   |  | 24b. ADDRESS<br><i>6224 Eastern Avenue</i>   |  |   |  |
| 25a. DATE REC'D.<br><i>JAN 3 1983</i>  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>James J. Connelley</i>  |  |   |  |

| Year | Month | Day | Time | Location  | Remarks |
|------|-------|-----|------|-----------|---------|
| 1919 | Jan   | 1   | 10   | St. Louis | Arrived |
| 1919 | Jan   | 1   | 11   | St. Louis | Left    |
| 1919 | Jan   | 1   | 12   | St. Louis | Arrived |
| 1919 | Jan   | 1   | 13   | St. Louis | Left    |
| 1919 | Jan   | 1   | 14   | St. Louis | Arrived |
| 1919 | Jan   | 1   | 15   | St. Louis | Left    |
| 1919 | Jan   | 1   | 16   | St. Louis | Arrived |
| 1919 | Jan   | 1   | 17   | St. Louis | Left    |
| 1919 | Jan   | 1   | 18   | St. Louis | Arrived |
| 1919 | Jan   | 1   | 19   | St. Louis | Left    |
| 1919 | Jan   | 1   | 20   | St. Louis | Arrived |
| 1919 | Jan   | 1   | 21   | St. Louis | Left    |
| 1919 | Jan   | 1   | 22   | St. Louis | Arrived |
| 1919 | Jan   | 1   | 23   | St. Louis | Left    |
| 1919 | Jan   | 1   | 24   | St. Louis | Arrived |
| 1919 | Jan   | 1   | 25   | St. Louis | Left    |
| 1919 | Jan   | 1   | 26   | St. Louis | Arrived |
| 1919 | Jan   | 1   | 27   | St. Louis | Left    |
| 1919 | Jan   | 1   | 28   | St. Louis | Arrived |
| 1919 | Jan   | 1   | 29   | St. Louis | Left    |
| 1919 | Jan   | 1   | 30   | St. Louis | Arrived |

1919 Jan 1 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8301307

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |   |   |  |   |
|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>RIDDICK LILLIE M RIDDICK</u>  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><u>1 29 83</u>   |  | 2b. HOUR<br><u>6<sup>30</sup> A M</u>   |
| 3. SEX<br><u>F</u>   | 4. RACE<br><u>B</u>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>5 23 24</u>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>58</u> YRS.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Virginia</u>   | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore City, MD.</u>                              |
| 10. CITY OR TOWN OF DEATH<br><u>Baltimore</u>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>University Hospital</u> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><u>Maryland</u> |   | 13b. COUNTY<br><u>Baltimore</u>   | 13c. CITY OR TOWN<br><u>Baltimore</u>                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>Sandy Stephens</u>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Amy Jones</u>   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>Yes</u>                                       |   | 16b. SOCIAL SECURITY NO.<br><u>N/A</u>  |  | 17. INFORMANT<br>ADDRESS<br><u>Joe Riddick 836 Edmondson Avenue</u>                             |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) unknown

1179  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) coagulopathy with thrombocytopenia

DUE TO, OR AS A CONSEQUENCE OF

(c) fungal pulmonary infection

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

chronic lymphocytic leukemia

|  |  |  |  |  |   |
|--|--|--|--|--|---|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/28</u> , 19 <u>83</u> , to <u>1/29</u> , 19 <u>83</u> , that (I) (we) last<br>saw the deceased alive on <u>1/29</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |
| 22b. SIGNATURE<br><u>DAVID POTZ</u>  |  | DEGREE<br><u>MD</u>  |  | 22c. DATE SIGNED<br><u>1/29/83</u>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Dr. Potz</u>   |  | 22e. ADDRESS<br><u>University Hosp., Balto. Md 21201</u>               |  |  |   |

|  |                            |   |   |
|--|----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br><u>BURIAL</u>             | 23b. DATE<br><u>2/4/83</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Md. Veteran Cem.</u> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Crownsville Md</u> |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Wm. C. March F/h Inc.</u> |                            | 25. DATE RECD. BY REGISTRAR<br><u>JAN 31 1983</u>             |   |
| ADDRESS<br><u>1101 E. North Ave.</u>                         |                            | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>              |   |



BOX 2 COTTON #1

DALEMAN



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial or cremation.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

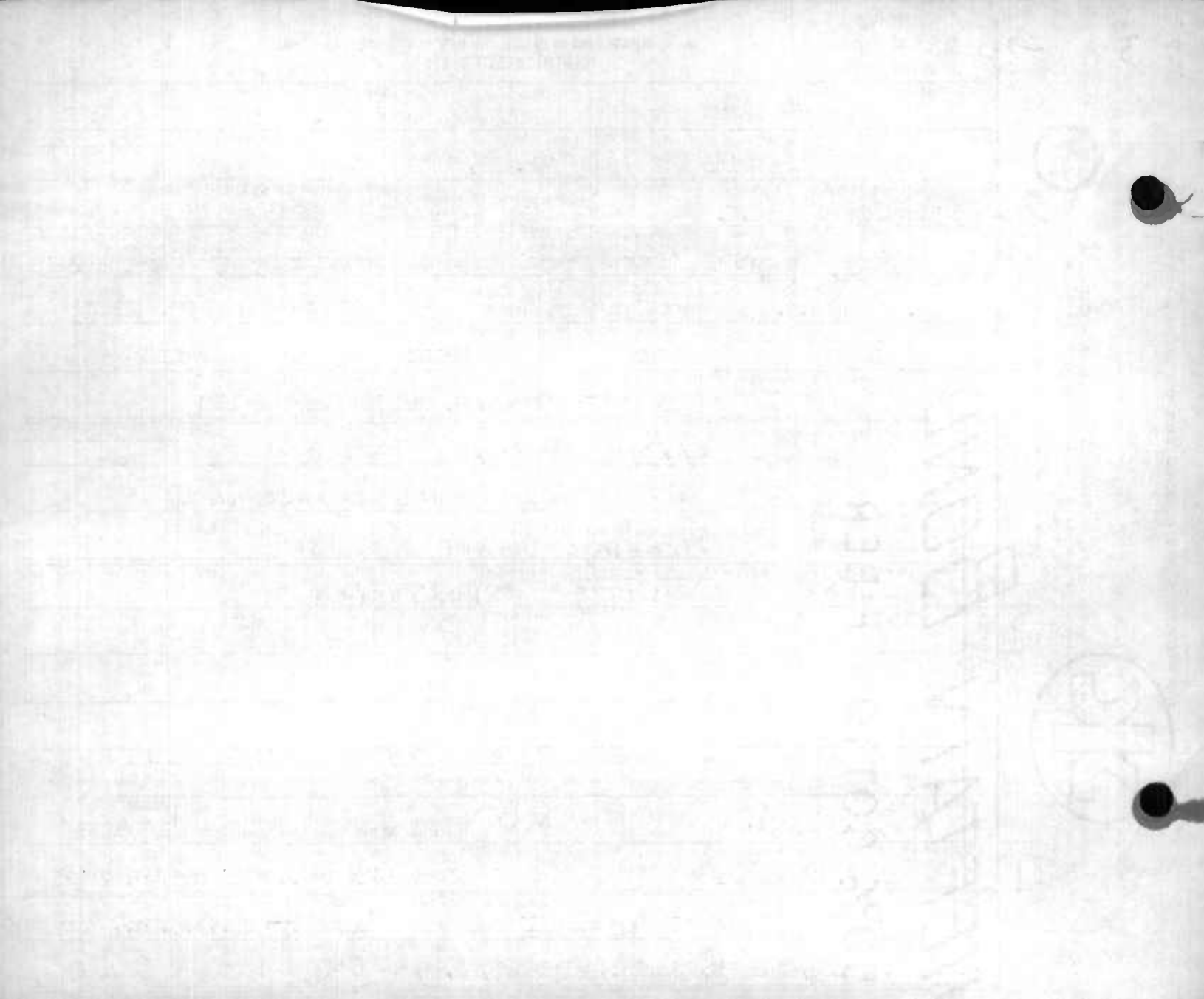
8 3 0 1 3 0 8

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |   |  |  |  |  |
|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>OKEY NEAL RIDDLE  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Jan. 3, 1983                                    |  | 2b. HOUR<br>4:43p M  |
| 3 SEX<br>Male  | 4 RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 17, 1908  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                               |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore General Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Interior Decorator |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Construction  |
| 13a. STATE<br>Md.  |   |  | 13b. COUNTY<br>A.A.  | 13c. CITY OR TOWN<br>Brooklyn Park   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>EDWIN RIDDLE   |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>DAISY RATLIFF                         |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |   | 16b. SOCIAL SECURITY NO.<br>233 26 5314  | 17. INFORMANT<br>ADDRESS<br>Freda B. Riddle (same as 13e)                              |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>4100 IMMEDIATE CAUSE (a) CARDIAC ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ACUTE MYOCARDIAL INFARCTION.<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) ISCHEMIC HEART DISEASE. |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)<br>C.O.P.D. PROSTATIC HYPERTROPHY.  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/3, 19 79, to 4/21, 19 82, that (I) (we) lost<br>saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |   |  |  |  |  |
| 22b. SIGNATURE<br>K. D'Harmasena   |   | DEGREE<br>M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  | 22c. DATE SIGNED<br>1/5/1983   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. K. D'Harmasena  |   | 22e. ADDRESS<br>8 West 16th Ave., Baltimore, Md. 21225   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   | 23b. DATE<br>1/7/1983   | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brooklyn Pk., A.A. Co., Maryland         |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>George J. Gonce, 4001 Ritchie Hg., Baltimore, Md.  |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 6 1983  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Conner   |  |

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 4/82  
(VRA 15, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 3 0 1 3 0 9  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Wilbur W. Ridgley</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>1 27 83</b>  |  | 2b. HOUR <b>12 45 A</b> M  |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 27, 1914</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mercy Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Fressman</b>  |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) CITY STATE COUNTY <b>Baltimore Maryland Howard</b>  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS <b>21043 8627 S. Bali Ct. Ellicott City</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>late Samuel Ridgley</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>late Kate</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>  |  | 16b. SOCIAL SECURITY NO. <b>WW 11 218 51 0370</b>  |  | 17. INFORMANT ADDRESS <b>21043 Mrs Velma Ridgley 8626 S Bali Ct Ellicott City</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1519 IMMEDIATE CAUSE (a) CARDIAC ARREST, CARDIAC FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>SEPSIS, HYPERTENSION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Metastatic Gastric Carcinoma, Diabetes Mellitus</b>   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION <b>1/20/83</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>GASTRIC CARCINOMA</b>  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/26/82</b> , 19 <b>82</b> , to <b>1/27</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>1/27/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |
| 22b. SIGNATURE <b>James J. [Signature]</b> and <b>M.D.</b>  |  |  |  | DEGREE   |  | 22c. DATE SIGNED <b>1/27/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. F. [Signature]</b>  |  |  |  | 22e. ADDRESS <b>Mercy Hospital Dept of Surg.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>Jan 29, 1983</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Crestlawn</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Howard, Maryland</b>  |  |
| 24. FUNERAL DIRECTOR NAME <b>Harry H Witzke</b> ADDRESS <b>4112 C Columbia Rd Ellicott City</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 28 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Joan J. [Signature]</b>  |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 3 0 1 3 1 0  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |  |  | CERTIFICATE OF DEATH   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  |  | 20. DATE OF DEATH  |  |  |  |
| FIRST MIDDLE LAST   |  |  |  | MONTH DAY YEAR   |  |  |  |
| JOHN D RIMAVICIUS   |  |  |  | 1 4 83   |  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  |
| MALE  |  | WHITE  |  | MONTH DAY YEAR   |  | 86 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| GEORGIA   |  | USA  |  |  |  | BALTO. CITY MD.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| BALTO CITY  |  | UNIVERSITY OF MARYLAND HOSP  |  | PRESSE R   |  | CLOTHING   |  |
| 13a. STATE  |  |  |  | 13b. COUNTY  |  |  |  |
| MD  |  |  |  | BALTO.   |  |  |  |
| 14. FATHER'S NAME   |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |
| FIRST MIDDLE LAST   |  |  |  | FIRST MIDDLE LAST  |  |  |  |
| UNKNOWN   |  |  |  | UNKNOWN  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |
| NO  |  |  |  | 09548-2102   |  |  |  |
| 17. INFORMANT   |  |  |  | ADDRESS  |  |  |  |
| ALDO MATIK  |  |  |  | 604 COLERAINE RD   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |
| 0399 IMMEDIATE CAUSE (a) SEPSIS   |  |  |  |  |  |  | ~ 24 HRS.                                    |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |
| RENAL FAILURE, SQUAMOUS CELL CANCER OF LUNG   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
|   |  | P.M. 19  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  |  |  |
|   |  |  |  | CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/4 19 83, to 1/4 19 83 that (I) (we) last saw the deceased alive on 1/4 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| Howard Jacobs MD  |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 1/4/83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |  |  |  |
| HOWARD JACOBS MD  |  |  |  | 22 S. Greene ST 21201  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  |
| BURIAL  |  | 1-8-83   |  | LOUDON PARK  |  | BALTO MD.  |  |
| 24. FUNERAL DIRECTOR  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                                     |  |
| WEBER FUNERAL HOME EDMONDSON AVE  |  |  |  | JAN 7 1983   |  | John J. Carver   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |   |  |   | 83 01311                         |   |  |  |
|--|--|--|--|---|--|--|---|--|---|----------------------------------|---|--|--|
| 1- FOR STATE REGISTRAR   |  |  |  |   |  |  |   |  |   | REG. NO.                         |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Benjamin E. Ritchie   |  |  |  |   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>01/13/83                     |  |   | 2b. HOUR<br>759 PM               |   |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 4 1904  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |   | 8. IF UNDER 24 HRS<br>HOURS MIN. |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Penna.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |   |  |   |                                  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Union Memorial Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RetRecord Admst  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Banking  |                                  |   |  |  |
| 13a. STATE<br>Md.  |  |  |  |   |  |  | 13b. CITY OR TOWN<br>Balto  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                  | 13e. STREET ADDRESS<br>8005 Apt B5 York Rd. |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles H Ritchie  |  |  |  |   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna L Emery       |  |   |                                  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>no   |  |  |  | 16b. SOCIAL SECURITY NO.<br>215 01 3498   |  | 17. INFORMANT<br>ADDRESS<br>Genevieve W. Ritchie Same                                |   |  |   |                                  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>1420 IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>METASTATIC CANCER OF PANCREAS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |  |   |  |   |                                  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>H/O CVA</u>   |  |  |  |   |  |  |   |  |   |                                  |   |  |  |
| 19a. DATE OF OPERATION<br><u>2/4</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>N/A</u>   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |                                  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |   |  |   |                                  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET   |  | CITY OR TOWN   |   | COUNTY   |   | STATE                            |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/12</u> , 19 <u>82</u> , to <u>01/13</u> , 19 <u>83</u> , that (I) (we) last saw the deceased on <u>1/13</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did, did not, view the body after death.  |  |  |  |   |  |  |   |  |   |                                  |   |  |  |
| 22b. SIGNATURE<br><u>[Signature]</u>   |  |  |  | DEGREE<br>M.D.  |  |  |   | 22c. DATE SIGNED<br>01/13/83   |   |                                  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Scott K. Luttge, M. D.  |  |  |  | 22e. ADDRESS<br>Union Memorial Hospital   |  |  |   |  |   |                                  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>1/17/1983   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley mem.Gds  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cockeysville Balto Md |  |   |                                  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Mitchell-Wiedefeld Home  |  |  |  |   |  | ADDRESS<br>6500 York Rd.   |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 19 1983   |   |                                  |   |  |  |
|  |  |  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                     |   |  |   |                                  |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, then death is attributable to the event and should be filed at a coroner's inquest.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8301312  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME<br>(FIRST MIDDLE LAST)<br><b>INEZ VIOLET ROBBINS</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 18 83</b>  |  | 2b. HOUR<br><b>5:00 P.M.</b>   |  |
| 1. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 8 17</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>            |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SOUTH BALTIMORE GEN. HOSP</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SALES</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Hutzlers</b>   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Dundalk</b>  |  | 13d. STREET ADDRESS<br><b>1212 Willow Road 21222</b>   |  |
| 14. FATHER'S NAME<br>(FIRST MIDDLE LAST)<br><b>BENJAMIN T. HICKS</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>(FIRST MIDDLE LAST)<br><b>ANNIE P. NORWOOD</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-22-7632</b>  |  | 17. INFORMANT<br>ADDRESS <b>1212 Willow Road</b><br><b>William G. Robbins-Balto., MD. 21222</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1479 IMMEDIATE CAUSE (a) RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>METASTATIC DISEASE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(c) <b>NASOPHARYNGEAL SQUAMOUS CELL CA</b> |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>-</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>-</b>   |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)<br><b>-</b>  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE, FARM, ETC.)<br><b>-</b>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>-</b>  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>DEC. 16</b> , 19 <b>82</b> , to <b>JAN. 18</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>JAN. 18</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.        |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Herbert Juarbe</b>  |  |   |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/18/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HERBERT JUARBE</b>   |  |   |  | 22e. ADDRESS<br><b>3001 S. HANOVER ST. BALTO., MD.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/22/1983</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holly Hill</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>White Marsh Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Duda=Ruck, Inc.</b> ADDRESS<br><b>7922 Wise Avenue Dundalk, MD. 21222</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 21 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 1/81  
(VRA 15, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   | 8 3 0 1 3 1 3  |  | REG. NO.   |  |
|---|--|--|--|---|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>MILDRED L. ROBERTS   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 11 83  |  | 2b. HOUR<br>8:30 A.M.                        |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>March 19, 1900  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Postal Worker    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Gov't.   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY 13c. CITY OR TOWN Baltimore   |  |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>605 E. 34th St. 21212 |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John L. Stone   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Dora Wolf  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br>Thornley L. Roberts,   |   |  | ADDRESS<br>Same                              |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Gangrene of Entire Small Bowel</u><br>5570<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |  |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION<br>1/9/83  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Acute abdomen  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from 1-11-83, 19 83, to 1-11, 19 83, that (we) last saw the deceased alive on 1-11, 19 83, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did/did not) view the body after death.   |  |  |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br>Frank Catanzariti MD  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   |  |  | 22c. DATE SIGNED<br>1/11/83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>FRANK CATANZARITI, M.D.  |  |  |  | 22e. ADDRESS<br>UNION MEMORIAL HOSPITAL   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>1/14/83   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Olivet  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Frederick MD                           |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., MD 21212   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 13 1983  |   | 25b. REGISTRAR'S SIGNATURE<br>John J. Canfield                                       |  |  |  |

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Buyer

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W. Oliver

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Johns & Sons Co.  
11th St  
Providence, R.I.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 01314

|   |  |  |  |
|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>OSCAR ROBERTS</b>   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1 31 83</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 2b. HOUR<br><b>3 P.M.</b>  |  |
| 4. RACE<br><b>CAU. CASIAN</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.  |  |
| 5. DATE OF BIRTH MONTH DAY YEAR<br><b>JUNE 15, 1907</b>   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balt City</b> MD.   |  |
| 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 12a. KIND OF BUSINESS OR INDUSTRY<br><b>BUILDING</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balt. City</b>  |  | 12b. BUILDING  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b>   |  | 12c. BUILDING  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  |
| 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>HYMAN RABORSKY</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>MAMIE DOPKIN</b>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>219-10-4538</b>   |  |
| 17. INFORMANT<br><b>MRS. MARY ROBERTS</b>   |  | 18. ADDRESS<br><b>3414 OLYMPIA AVE. BALTO., MD 21215</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiovascular - Resp. Failure</b><br><b>1579</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Pancreatic Cancer</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1mm.</b> |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |
| 19a. DATE OF OPERATION<br><b>8-82</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  | 21d. INJURY OCCURRED   |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |
| 22b. SIGNATURE<br><b>Michael S. Morris M.D.</b>   |  | 22c. DATE SIGNED<br><b>1-31-83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Michael S. Morris</b>   |  | 22e. ADDRESS<br><b>Sinai Hospital</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>FEB. 2, 1983</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>WORKMEN CIRCLE</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS., INC.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 7 1983</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Joan J. Conish</b>   |  |  |  |

MEDICAL CERTIFICATION

99

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE DIRECTOR, BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

FROM THE DIRECTOR, BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

RE: [illegible]

[illegible]

[illegible]

[illegible]

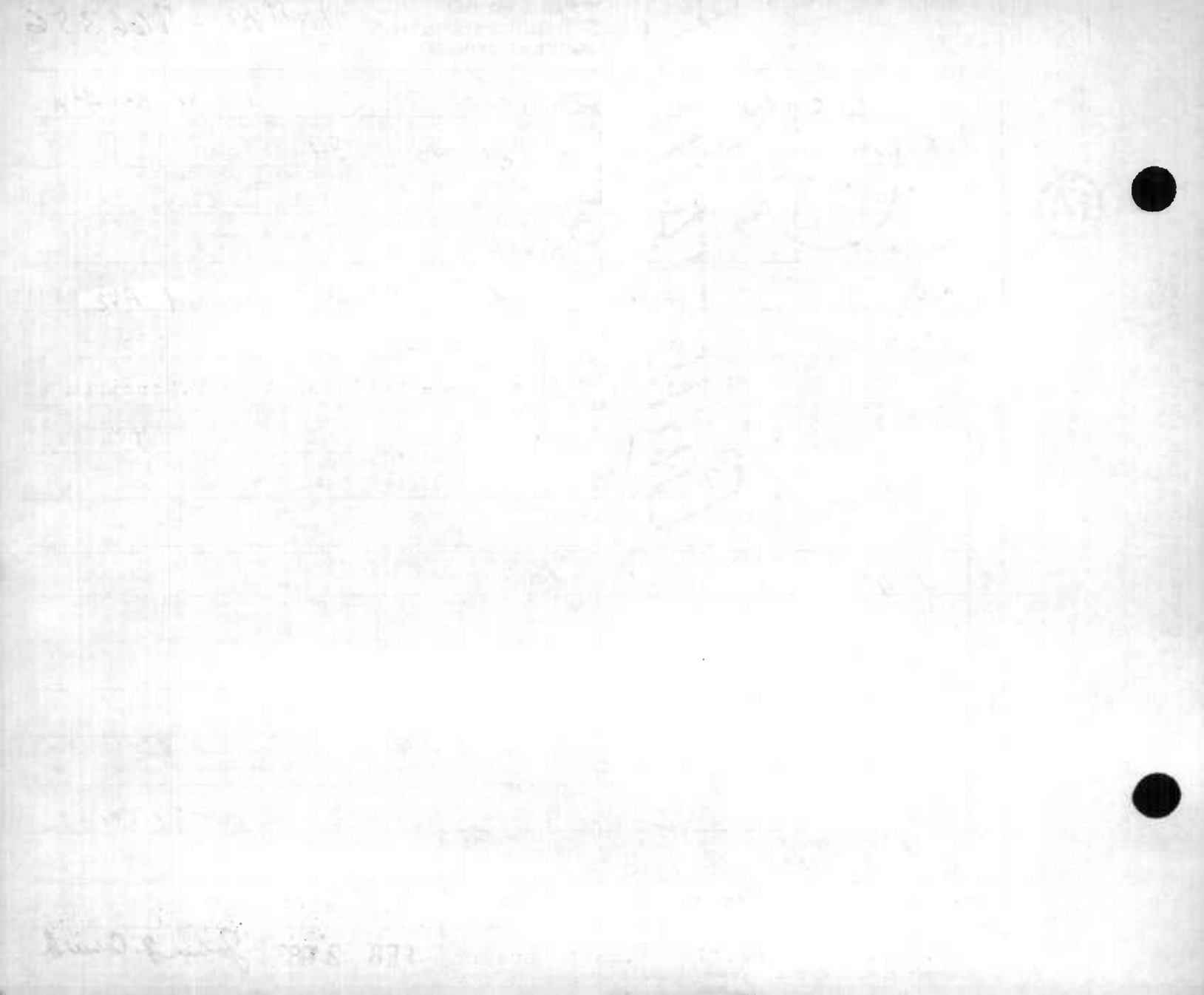
FEB 2 1917

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |  |  |
|---|--|---|--|--|--|--|--|--|--|
| <div style="text-align: right;">Unit No 07663156<br/>REG. NO. 01315</div>   |  |   |  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CAROLYN Y. Robinson</b>  |  |   |  |  |  | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>31</b> YEAR <b>83</b>                     |  | 2b. HOUR<br><b>420 A M</b>   |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>5</b> DAY <b>27</b> YEAR <b>48</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>34</b> YRS.                                     |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b><br>IF UNDER 24 HRS<br>HOURS <b></b> MIN. <b></b>                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                    |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAL</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD.</b>  |  | 13b. COUNTY<br><b>BALTO</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>3905 W. Garrison Ave. 21215</b>                            |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Cleveland</b> MIDDLE <b></b> LAST <b>Scott</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Dorothy</b> MIDDLE <b></b> LAST <b>Withers</b>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-46-6353</b>  |  | 17 INFORMANT<br>ADDRESS<br><b>Sharron Robinson 3905 W. Garrison Ave.</b>   |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1830 IMMEDIATE CAUSE (a) Hypocausion</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>(b) metastatic ovarian CA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>(c)</b> |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Hepatic &amp; renal failure</b>   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-31-83</b> , 19 <b>83</b> , to <b>1/31</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>1-31</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.           |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Robert L. Kiam</b>   |  |   |  | DEGREE<br><b>910 J.</b>  |  |  |  | 22c. DATE SIGNED<br><b>1-31-83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e. ADDRESS   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>2/3/83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Auburn Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b></b> STATE <b>Md.</b>       |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm. C. March F/H Inc.</b> ADDRESS <b>1101 E. North Avenue</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 2 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conish</b>                                  |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 2 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST <u>KERRY</u> MIDDLE <u>ELLEN</u> LAST <u>ROBINSON</u>   |  | 2a. DATE OF DEATH MONTH <u>1</u> DAY <u>20</u> YEAR <u>83</u>  |  | 2b. HOUR <u>8:10 P.M.</u>  |  |
| 3. SEX <u>Female</u>  |  | 4. RACE <u>White</u>  |  | 5. DATE OF BIRTH MONTH <u>Nov.</u> DAY <u>25</u> YEAR <u>1944</u>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <u>38</u> YRS. MONTHS <u></u> DAYS <u></u> HOURS <u></u> MIN. <u></u>                              |  |
| 7a. BIRTHPLACE <u>Washington</u>  |  | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore</u> City MD.   |  |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>University of Maryland (Chick-Training)</u> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Homemaker</u>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>  |  |
| 13a. STATE <u>Maryland</u>  |  | 13b. COUNTY <u>A.A.</u>   |  | 13c. CITY OR TOWN <u>Crownsville</u>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  |
| 14. FATHER'S NAME FIRST <u>Walter</u> MIDDLE <u>M.</u> LAST <u>Faver</u>  |  | 15. MOTHER'S MAIDEN NAME FIRST <u>Irene</u> MIDDLE <u>L.</u> LAST <u>Mashburn</u>   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> (IF YES, GIVE WAR OR DATES) <u>N/A</u>  |  |  |  |
| 16b. SOCIAL SECURITY NO. <u>223.62.3631</u>   |  | 17. INFORMANT (husband) ADDRESS <u>Same as # 13</u> Mr. Ralph R. Robinson   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><u>8199</u> IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>Respiratory Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Trauma</u> |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Ruptured Aorta, ARDS</u>  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION <u>multiple</u>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Ruptured Aorta</u>  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>Motor Vehicle Accident</u>  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |  |  |
| 22b. SIGNATURE <u>Howard Belzberg</u> M.D.  |  | DEGREE <u>MD</u>  |  | 22c. DATE SIGNED <u>1/20/83</u>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Howard Belzberg</u>  |  | 22e. ADDRESS <u>22 S. Greene St.</u>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>   |  | 23b. DATE <u>24 Jan. 83</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Knights of Pythias Cemetery</u>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Salem-Harrison-W. VA.</u>   |  |
| 24. FUNERAL DIRECTOR'S NAME <u>Singleton Funeral Home</u>   |  | ADDRESS <u>Glen Burnie MD.</u>  |  | 25a. DATE REC'D. BY REGISTRAR <u>JAN 25 1983</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>Joan J. Carver</u>   |  |

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RECEIVED BY THE DIRECTOR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8301317<br>REG. NO.   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>MARY EMELIA Robinson  |  |  |  |
| 2a. DATE OF DEATH MONTH DAY YEAR<br>01/25/1983   |  |  |  | 2b. HOUR<br>135 PM  |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>white   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>DEC. 6, 1926   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>56 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>STATISTICIAN   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>SOUTHLAND CORP.   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN WOODLAWN   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 5706 JOHNNYCAKE ROAD 21207                 |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>WILLIAM H. STRICKER   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>EVELYN MARIE WILL   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO   |  |  |  | 16b. SOCIAL SECURITY NO.<br>217-22-5228   |  | 17. INFORMANT ADDRESS<br>MR. JOHN ROBINSON SAME AS # 13  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4100 IMMEDIATE CAUSE (a) OCCLUSION, RIGHT CORONARY ARTERY<br>DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROSIS<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>Michael E Pelczar  |  |  |  | 22c. DATE SIGNED<br>1/27/83   |  | 22d. ADDRESS<br>ST. AGNES HOSP, BALTIMORE, MARYLAND  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>1/28/83   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>CRESTLAWN CEMETERY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>MARRIOTTSTVILLE MARYLAND  |  |
| 24. FUNERAL DIRECTOR'S NAME<br>LEROY M. & RUSSELL C. WITZKE FUNERAL HOME   |  |  |  | 25. REGISTRAR'S SIGNATURE<br>John J. Conner   |  |  |  |
| 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228  |  |  |  | JAN 26 1983   |  |  |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |                  |                 |  |  |   |  |   |                |                                |  |  |  |   |                         |  |  |           |  |  |              |  |  |               |  |  |
|--|--|------------------|-----------------|--|--|---|--|---|----------------|--------------------------------|--|--|--|---|-------------------------|--|--|-----------|--|--|--------------|--|--|---------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                  | FIRST<br>GEORGE |  |  | MIDDLE<br>G.                                  |  |   | LAST<br>ROCKEL |                                |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED                                   |  |   | MONTH<br>1              |  |  | DAY<br>18 |  |  | YEAR<br>1983 |  |  | 2b. HOUR<br>M |  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE |                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JAN 24 1930  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>52 YRS. |  | IF UNDER 1 YR.<br>MONTHS DAYS   |                | IF UNDER 24 HRS.<br>HOURS MIN. |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>1 18 1983                |  |   | 2d. HOUR<br>a M<br>9:47 |  |  |           |  |  |              |  |  |               |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  |                  |                 | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                |                                |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.             |  |   |                         |  |  |           |  |  |              |  |  |               |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |                 | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>6414 Harford Rd. |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MECH.  |                |                                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>FRAME RITE                        |  |   |                         |  |  |           |  |  |              |  |  |               |  |  |
| 13a. STATE<br>MO.  |  |                  |                 | 13b. CITY OR TOWN<br>BALTO.  |  |   |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                |                                |  | 13d. STREET ADDRESS<br>2438 ELLIS ROAD 21234                           |  |   |                         |  |  |           |  |  |              |  |  |               |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>AUGUST   |  |                  |                 | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARY DVORAK   |  |   |  |   |                |                                |  |  |  |   |                         |  |  |           |  |  |              |  |  |               |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>YES   |  |                  |                 | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>KOREA 212-283491  |  |   |  | 17. INFORMANT<br>FAMILY RECORDS   |                |                                |  | ADDRESS  |  |   |                         |  |  |           |  |  |              |  |  |               |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  |  |                  |                 |  |  |   |  |   |                |                                |  |  |  |   |                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |           |  |  |              |  |  |               |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |  |                  |                 |  |  |   |  |   |                |                                |  |  |  |   |                         |  |  |           |  |  |              |  |  |               |  |  |
| 19a. DATE OF OPERATION   |  |                  |                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |                |                                |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                         |  |  |           |  |  |              |  |  |               |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                |                                |  |  |  |   |                         |  |  |           |  |  |              |  |  |               |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |                  |                 | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                |                                |  |  |  |   |                         |  |  |           |  |  |              |  |  |               |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |                 |  |  |   |  |   |                |                                |  |  |  |   |                         |  |  |           |  |  |              |  |  |               |  |  |
| ACTUAL SIGNATURE<br>Ann M. Dixon, M.D.   |  |                  |                 | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER   |  |   |  | DATE SIGNED<br>1-18-83  |                |                                |  |  |  |   |                         |  |  |           |  |  |              |  |  |               |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  |                  |                 | ADDRESS<br>111 Penn St., Balto., Md. 21201   |  |   |  |   |                |                                |  |  |  |   |                         |  |  |           |  |  |              |  |  |               |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |                  |                 | 23b. DATE<br>JAN 22 1983   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley  |                |                                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Timonium BALTO. MARYLAND |  |   |                         |  |  |           |  |  |              |  |  |               |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>EVANS FUNERAL CHAPEL   |  |                  |                 | ADDRESS<br>8800 HARFORD RD.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 27 1983  |                |                                |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Smith                            |  |   |                         |  |  |           |  |  |              |  |  |               |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem examinations should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

| FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 3 0 1 3 1 9<br>REG. NO.   |  |  |  |
|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WILBUR WINCHESTER ROGERS</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1-7-83</b>   |  |  |  | 2b. HOUR<br><b>7:25A M</b>  |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Cauc.</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>1/15/12</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b>   |  | IF UNDER 1 YEAR MONTHS DAYS<br><b>YRS.</b>  |  | IF UNDER 24 HRS. HOURS MIN.<br><b>YRS.</b>   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VAMC LOCH RAVEN BLVD. BALTO. MD</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>----</b>  |  |  |  |
| 13a. STATE<br><b>Md.</b>   |  |  |  | 13b. COUNTY<br><b>----</b>  |  | 13c. CITY OR TOWN<br><b>Balto.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3117 Guilford Ave. 21218</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>? MIDDLE</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>? MIDDLE</b>   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>WW2 577 22 1324</b>  |  | 17. INFORMANT ADDRESS<br><b>Allen Dawson Hyattsville, Md.</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Embolism → Cardiac Arrest</b><br><b>4151</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>January 3, 1983</b> , to <b>January 7, 1983</b> , that (X) (we) last saw the deceased alive on above, (X) (we) (did) (not) view the body after death.  |  |  |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Alexander Jones MD.</b>   |  |  |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/7/83</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ALEXANDER JONES MD.</b>  |  |  |  | 22e. ADDRESS<br><b>3900 Loch Raven Blvd. Balto., Md 21218</b>   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/10/83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Pk.</b>   |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>                                    |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Paul E. Chenoweth 3rd. 3617 Chestnut Ave.</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 13 1983</b>  |  |   |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 3 2 0

REG. NO.

|  |  |   |   |  |   |
|--|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Russell R. Roland</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-7-83</b>  |   | 2b. HOUR<br><b>2:25a M</b>   |   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 29 26</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b> YRS.                                    |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Wyman Park Health System</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PSG/E7</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Gov't</b>            |
| 13a. STATE<br><b>Maryland</b>  | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Roland</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Laura Steffey</b>   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>196-12-6276</b>  |   | 17. INFORMANT ADDRESS<br><b>Dorothy Roland (wife) same address</b>                   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>1991</b> IMMEDIATE CAUSE (a) <b>Cardio-respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pulmonary infiltrates</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Metastatic Adenocarcinoma unknown primary site</b>      |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>minutes</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a-  |  |   |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>December 13, 1982</b> to <b>January 7, 1983</b> , that (I) (we) lost saw the deceased alive on <b>January 7, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |   |
| 22b. SIGNATURE<br><b>Phyllis E. Nicholson M.D.</b>   |  | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>1/7/83</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Phyllis E. Nicholson</b>   |  | 22e. ADDRESS<br><b>3100 Wyman Park Dr. Balto., Md. 21211</b>  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>1/10/83</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crownsville Vet/ Cem.</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crownsville Md.</b>                 |   |
| 24. FUNERAL DIRECTOR'S NAME<br><b>Schimunek Funeral Home, Inc.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 7 1983</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                     |   |
| 24. FUNERAL DIRECTOR'S ADDRESS<br><b>3331 Brehms Lane, Balto. Md. 21213</b>  |  |   |   |  |   |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  | 83 01321                                     |  |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.   |  |   |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>EARL H. Roman SR.</b>   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>January 23 83</b>  |  | 2b. HOUR<br><b>1:45 PM</b>   |  |  |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>white</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>6 26 09</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY) <b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CATON MANOR NURSING CENTER</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MOLD MAKER</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>GLASS CO.</b>  |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>---</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2505 ARBUTON AVENUE, 21230</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GEORGE ROMAN</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CATHERINE EINHOLF</b>   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>214-01-4677</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>MARY E. ROMAN 2505 ARBUTON AVENUE, 21230</b>   |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST.</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><b>POSSIBLE ASPIRATION</b>   |  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>N/A</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>N/A</b>   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)<br><input checked="" type="checkbox"/> <b>N/A</b>   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)<br><b>N/A</b>  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> <b>N/A</b>  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM, ETC.)<br><b>N/A</b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>N/A</b>   |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <b>1-23-</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1-22-</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Surjit Julka</b>  |  |  |  | DEGREE<br><b>MD</b>   |  |   |  | 22c. DATE SIGNED<br><b>1-24-83</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Surjit Julka</b>   |  |  |  | 22e. ADDRESS<br><b>107 E. Saratoga Street</b>   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>01-27-83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MEADOWRIDGE MEM. PK.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ELKRIDGE HOWARD MARYLAND</b>                   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home, Inc.</b>  |  |  |  | ADDRESS<br><b>4107 Wilkens Ave.</b>   |  | 25a. DATE RECD. BY REGISTRAR<br><b>JAN 26 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>  |  |  |  |

Hubbard T. Marshall, Inc. 4101 Wilshire Ave. S.W.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 3 2 2

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |   |   |  |   |  |
|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARSHALL ELLIOTT RONEY</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 / 7 / 83</b>                                 |   | 2b. HOUR<br><b>10 20 AM</b>  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>C White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 17 19 63</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b><br>YRS MONTHS DAYS                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PA.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALT. CITY</b> MD.                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>30. BALT. GEN. HOSP</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HORSE GROOMER</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Laurel Raceway</b>   |
| 13a. STATE<br><b>MD.</b>  |   | 13b. COUNTY<br><b>.</b>   | 13c. CITY OR TOWN<br><b>BALT.</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>4034 1/2 SIXTH ST. 21225</b>   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WARREN William RONEY</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LYDIA Emmaline SPEAKMAN</b>          |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>YES UNK WW11</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>220-03-6595</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>EMILY DORSCH SAME As #13e</b>                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4275 Cardio pulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____                  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that <u>117</u> (this hospital) attended the deceased from <u>12/11</u> , 19 <u>82</u> , to <u>1/7</u> , 19 <u>83</u> , that (1) <u>two</u> lost saw the deceased alive on <u>1/7</u> , 19 <u>83</u> , and that in (my) <u>four</u> opinion death occurred on the date and hour and from the causes stated above. (If two died and not view the body after death.) |   |   |  |   |  |
| 22b. SIGNATURE<br><i>[Signature]</i>  |   | DEGREE  |  | 22c. DATE SIGNED<br><b>1/7/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>E. L. Akerberg</b>  |   | 22e. ADDRESS<br><b>South Baltimore General Hosp.</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |   | 23b. DATE<br><b>1-10-83</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Crematory</b>                       |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc.</b>   |   | ADDRESS<br><b>1050 York Rd. Towson, Md. 21204</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 11 1983</b>   |  |
|   |   |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

APPROPRIATE

REMARKS

TIME

LOCATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |                            | 8 3 0 1 3 2 3   |  |  |  |
|---|--|--|--|---|--|--|--|--|----------------------------|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   |  |  |  |  |                            | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>CHARLES O. ROPER, Jr.</b>  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1 2 83</b>                                |  |  |  | 2b. HOUR<br><b>4:30 PM</b> |   |  |  |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Feb. 27 1913</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS  |                            | IF UNDER 24 HRS. HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Florida</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                            |  |  |                            |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Dept. Vital Records</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>St. of Md.</b>   |                            |   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>5641 Purdue Ave. Apt. D</b>  |                            |   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Charles O. Roper, Sr.</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Francis E. Happoldt</b>         |  |  |  |                            |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes</b>   |  |  |  |   | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>WW II 215-10-1383</b> |  | 17. INFORMANT ADDRESS<br><b>Evelyn Roper 5641 Purdue Ave. Baltimore, Md.</b> |  |                            |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOGENIC SHOCK</b><br><b>2502</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>DIABETIC HYPEROSMOLAR COMA</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>lower lobe pneumonia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |   |  |  |  |  |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>20 hrs</b>   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |  |                            |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>N/A</b>  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>N/A</b>  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)               |  |  |                            |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |                            |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/1/83</b> to <b>1/2/83</b> , that (I) (we) last saw the deceased alive on <b>1/1/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death   |  |  |  |   |  |  |  |  |                            |   |  |  |  |
| 22b. SIGNATURE<br><b>COOL-FOLEY</b>   |  |  |  | DEGREE  |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                            | 22c. DATE SIGNED<br><b>1/2/83</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>COOL-FOLEY</b>  |  |  |  | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>  |  |  |  |  |                            |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  |  | 23b. DATE<br><b>Jan. 6, 1983</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>                            |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>   |                            |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>JAN 4 1983 John J. Conner</b> |  |  |                            |   |  |  |  |

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CHARGE, 1917

BALTIMORE CITY

UNION MEMORIAL HOSPITAL

BALTIMORE

Chas. W. Jones  
1917

UNION MEMORIAL HOSPITAL

1917



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 3 2 4

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Henry Roscoe</b>                        |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 18, 1983</b> |   |  | 2b. HOUR<br><b>1:35P M</b>  |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 11 03</b>  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>79</b> YRS.               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N. Carolina</b>                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD. |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY   |  | 13c. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>   |  | 13d. STREET ADDRESS<br><b>942 N. Washington St. 21205</b>         |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Granville Roscoe</b>                 |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nancy</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |  | 16b. SOCIAL SECURITY NO.<br><b>213-07-1416</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Johnnie Mae Roscoe 942 N. Washington St.</b>   |  |   |  |

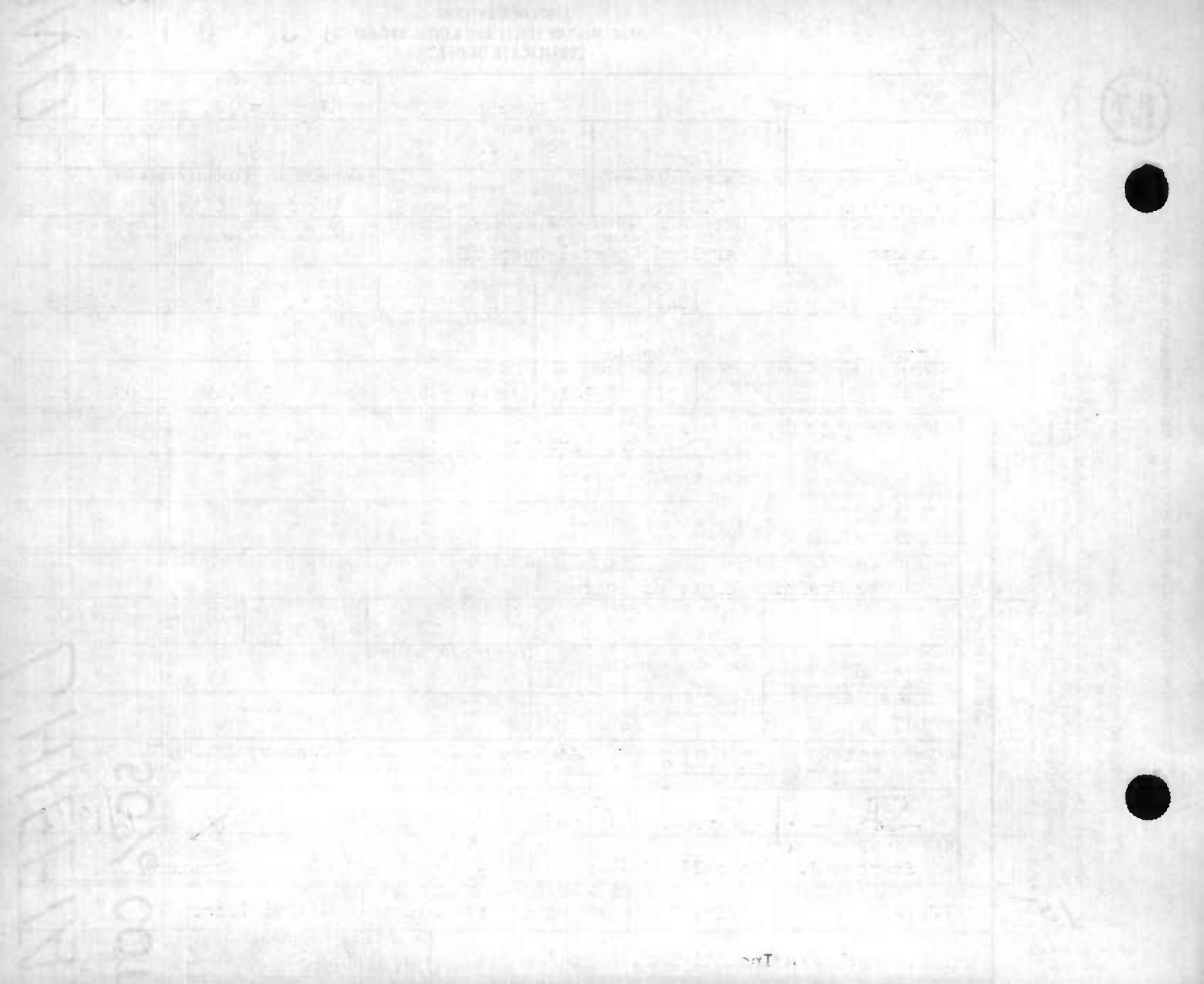
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest</b><br><b>4275</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
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| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Huge Draining Ulcer of Sacrum</b>  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that <b>X</b> (this hospital) attended the deceased from <b>January 9, 1983</b> to <b>January 18, 1983</b> , that <b>X</b> (we) last saw the deceased alive on <b>January 9, 1983</b> , and that in <b>X</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>X</b> (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><b>Stephen J. O'Connell</b>  |  | 22c. DATE SIGNED<br><b>1/19/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Stephen J. O'Connell, M.D.</b>   |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>   |  |

|  |  |                             |  |   |  |   |  |
|--|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b> |  | 23b. DATE<br><b>1/24/83</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garden of Eternal Hope</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Westminister Md.</b> |  |
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| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H Inc. 1101 E. North Avenue</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 20 1983</b> |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connell</b> |  |
|---|--|---|--|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 3 2 5

REG. NO.

|  |  |  |  |  |  |   |  |  |   |  |  |
|--|--|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>FLORENCE</b>  |  |  | LAST <b>ROSEMAN</b>  |  |  | 2a. DATE OF DEATH MONTH <b>11</b> DAY <b>1</b> YEAR <b>83</b>   |  |  | 2b. HOUR <b>9:45 P.M.</b>   |  |  |
| 3. SEX <b>FEMALE</b>   |  |  | 4. RACE <b>WHITE</b>   |  |  | 5. DATE OF BIRTH MONTH <b>12</b> DAY <b>10</b> YEAR <b>02</b>   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> 80 YRS.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>            |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore city</b> MD.  |  |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lovindale Nursing Home</b> |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>  |  |  |
| 13a. STATE <b>MARYLAND</b>   |  |  | 13b. COUNTY <b>BALTIMORE</b>   |  |  | 13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>  |  |  | 13e. STREET ADDRESS <b>3712 FORDS LA., APT. B #21215</b>  |  |  |
| 14. FATHER'S NAME FIRST <b>BEN</b> MIDDLE <b>HERMAN</b> LAST <b>HERMAN</b>   |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>REBECCA</b> MIDDLE <b>JACOBS</b> LAST <b>JACOBS</b>  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO. <b>219-32-7119</b>   |  |  |
| 16c. SOCIAL SECURITY NO. <b>219-32-7119</b>  |  |  | 17. INFORMANT <b>MR. LEONARD HERMAN</b>  |  |  | 17a. ADDRESS <b>3198 OLD POST RD. BALTO., MD 21208</b>  |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Cancer to Brain</b><br><b>1991</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>(Primary unknown)</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Few months</b>  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>C.V.A. with left hemiplegia, Hypertension.</b>   |  |  |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b> P.M.  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>8/25/82</b> to <b>1/1/83</b> , that <del>x</del> (we) last saw the deceased alive on <b>9:30 pm 1/1/83</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>do</del> (did) <del>not</del> view the body after death.                        |  |  |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE <b>[Signature]</b>  |  |  | DEGREE <b>MD</b>   |  |  | ATTENDING <input checked="" type="checkbox"/> MEDICAL PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED <b>1/1/83</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ICHIN M. TUN</b>  |  |  | 22e. ADDRESS <b>Lovindale Geriatric Hospital.</b>  |  |  |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  |  | 23b. DATE <b>JAN. 4, 1983</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>MIKRO KODESH-BETH ISRAEL</b>  |  |  | 23d. LOCATION CITY OR TOWN <b>BALTIMORE</b> COUNTY <b>MARYLAND</b>  |  |  |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b>   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 6 1983</b>   |  |  |   |  |  |
| 6010 REISTERSTOWN RD. BALTO., MD 21215   |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |  |   |  |  |

BP

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8301326

REG. NO.

|   |  |   |  |  |  |   |  |  |
|---|--|---|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  |   | 2a. DATE OF DEATH  |  |  | 2b. HOUR  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>SADIE G. ROSEN   |  |   | MONTH DAY YEAR<br>1 - 23 - 1983  |  |  | 240A M  |  |  |
| 3. SEX<br>FEMALE  | 4. RACE<br>CAUCASIAN   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 - 28 - 1910  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.                                 |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                 |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>LEVINDALE GERIATRIC CNTR |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME  |  |  |
| 13a. STATE<br>MARYLAND  |  |   | 13b. COUNTY<br>BALTIMORE   |  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOSEPH I. GOLDBERG  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARY ROYPEN               |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)<br>NO   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>252-09-3892D    |  |  | 17. INFORMANT<br>MURRAY ROSEN APT. 201<br>7732 HANOVER PKWY. GREENBELT, MD 20770                |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio-respiratory failure.<br>1749 DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Adenocarcinoma of the breast (bone & lung).<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                           |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                 |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)     |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-5-1983, to 1-23-1983, that (I) (we) lost<br>saw the deceased alive on 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |   |  |  |
| 22b. SIGNATURE<br>[Signature]<br>DEGREE<br>M.D.   |  |   |  |  |  | 22c. DATE SIGNED<br>1-23-83   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SEI HTWAR  |  |   |  |  |  | 22e. ADDRESS<br>Levindale Hebrew Geriatric Ctr<br>Belvedere & Green Spring Ave, Balto. 21215    |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  |   | 23b. DATE<br>JAN. 24, 1983   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BETH TFILOH   |  |  |
| 23d. LOCATION<br>BALTIMORE  |  |   | 23e. COUNTY<br>MARYLAND  |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>ADDRESS 60 S. REISTERSTOWN RD. BALTO., MD 21215  |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 26 1983  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |   |  |  |  |   |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicare carrier must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 8301327  |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>LENA ROSENBAUM  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>JANUARY 24, 1983  |  |   |  |
| 3 SEX<br>FEMALE   |  | 4 RACE<br>WHITE  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>MAY 30, 1889   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>93  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>POLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3012 ROMARIC CT., APT. F |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE MARYLAND 13c. COUNTY BALTIMORE   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>3012 ROMARIC CT., APT. F 21209   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>JOSEPH STEINER   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>MOLLIE UNKNOWN  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>218-32-0926  |  | 17. INFORMANT ADDRESS<br>JACK ROSENBAUM<br>1019 PARK VALLEY RD. BALTO., MD 21208  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u><br>4409<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>A. Terio salmon</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Months</u><br><u>Year</u> |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 1975</u> to <u>Jan 24, 1983</u> , that (I) (we) lost <u>saw the deceased alive on Dec 27, 1982</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |
| 22b. SIGNATURE <u>David J. Miller</u> DEGREE  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br>1-24-83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DAVID MILLER, M.D.   |  |  |  | 22e. ADDRESS<br>10219 S. DOLFIELD RD. OWINGS MILLS, MD  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>JAN. 26, 1983   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>OLD RUDOMER VEREIN  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>ROSEDALE BALTO. MD   |  |
| 24. FUNERAL DIRECTOR NAME<br>SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 1 1983   |  | 25b. REGISTRAR'S SIGNATURE <u>John J. Miller</u>  |  |

M

John D. Wright

52-15-1

Det. P. H. H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  | 83 01328                                      |  |  |  |
|--|--|---|--|---|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.  |  |   |  |   |  |  |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Olaf A. Roughtvedt, Sr.</b>   |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 29 83</b>   |  |  |  | 2b. HOUR<br><b>M</b>                          |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 28 14</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>1 29</b>  |  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>1 29</b> |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Norway</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>722 N. Chapelgate Lane</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Seaman Captain</b>          |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>722 N. Chapelgate La.</b>  |  |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Olaf A. Roughtvedt</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Maria Rie</b>   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |   |  |  |  |   |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>082-22-0940</b>   |  | 17. INFORMANT<br><b>Mrs. Rose B. Roughtvedt #21229</b>  |  |   |  |   |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Stabbing Epileptics - Aspiration</b><br><b>3314</b><br>Conditions, if any, which gave rise to immediate cause (b) <b>Alcoholism with ventric-</b><br>underlying cause (c) <b>Cholelithiasis and stent.</b><br>DUE TO OR AS A CONSEQUENCE OF<br>DUE TO OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |   |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>10-1-83</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-22-82</b> to <b>1-29-83</b> , that (I) (we) lost saw the deceased alive on <b>10-22-82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Angov</b>   |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |   |  | 22c. DATE SIGNED<br><b>1-31-83</b>   |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>George Angov, M. D.</b>  |  | 22e. ADDRESS<br><b>3356 Wilkman Dr. Baltor</b>  |  |   |  |   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>2-2-83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Mem. Pk. Cem. Baltor</b>  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Nat'l. Pike</b>  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>G. Truman Schwab</b>  |  | 5151 Balto. Nat'l. Pike   |  | FEB 7 1983  |  |   |  | 25a. DATE REC'D. BY REGISTRAR OR REGISTRAR'S SIGNATURE<br><b>John J. Cahill</b>  |  |   |  |  |  |

RECEIVED  
FEB 10 1964  
U.S. DEPARTMENT OF JUSTICE



TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK  
SUBJECT: [illegible]

RE: [illegible]  
[illegible]  
[illegible]

DATE: [illegible]  
[illegible]  
[illegible]

EX-100-100000-1

1-10-64  
[illegible]  
[illegible]  
[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   | 8 3 0 1 3 2 9  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR  |  |   |  |   | REG. NO.   |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>PERCY A ROY</i>   |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>1-21-83</i>   |   |  |  | 2b. HOUR<br><i>8:30A M</i>                   |
| 3 SEX<br><i>MALE</i>  |  | 4 RACE<br><i>BLACK</i>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>6-6-04</i>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><i>78</i> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>VIRGINIA</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U S A</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTIMORE</i> city MD.                                |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><i>BALTIMORE</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>LUTHERAN Hospital &amp; Md</i> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY                    |  |
| 13a. STATE<br><i>Md</i>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><i>Baltimore</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>3137 Belmont Ave 21216</i> |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><i>N/A</i>  |  |   |  |   | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Lena Roy</i>   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>217-03-8031</i>  |  | 17 INFORMANT ADDRESS<br><i>Ernestine Jones 3137 Belmont Ave</i>   |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>cardiopulmonary arrest</i><br><i>1950</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Prostatic ca &amp; probable metastasis.</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) |  |   |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1-8-83</i> , 19 <i>83</i> to <i>1-21</i> , 19 <i>83</i> that (I) (we) lost saw the deceased alive on <i>1-21</i> , 19 <i>83</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.              |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Cashah</i>   |  |   |  |   | DEGREE<br><i>MD</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><i>21 1/21/83</i>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>DR. G. SHAH</i>   |  |   |  |   | 22e. ADDRESS<br><i>790 Ashbuston St. Balto 21216 Md</i>  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>1/26/83</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Mt Calvary Cem</i>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Anne Arundel Co Md</i>                            |  |  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><i>William C. March F/H 1101 E. North Ave</i>  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 24 1983</i>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Joan J. Conner</i>  |  |  |

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 3 3 0

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |  |  |  |  |  |   |  |  |
|---|--|--|---|--|--|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LEONARD</b>  |  |  | FIRST MIDDLE LAST   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |  | 2b. HOUR  |  |  |
| 3. SEX <b>male</b>  |  |  | 4. RACE <b>CAUCASIAN</b>  |  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>1 15 18</b>   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND USA</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore md</b>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b>  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOME IMPROVEMENT</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>BUILDING</b>   |  |  |
| 13a. STATE <b>MARYLAND</b>  |  |  | 13b. COUNTY <b>BALTIMORE</b>  |  |  | 13c. CITY OR TOWN <b>BALTIMORE</b>   |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>SAMUEL RUBIN</b>   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MOLLYE ROBBIN LEVIN</b>   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>   |  |  | 16b. (IF YES, GIVE WAR OR DATES) <b>WWII-ARMY</b>   |  |  |
| 17. INFORMANT ADDRESS <b>SELMA RUBIN 3310 NERAK RD.</b>   |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>DEHYDRATION</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>metastatic CA.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CA of colon</b> |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>2 yrs</b> <b>7 yrs</b>   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>1539</b>  |  |  |   |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-4</b> 19 <b>83</b> , to <b>1-4</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1-4</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |  |  |  |   |  |  |
| 22b. SIGNATURE <b>Marco Roffe</b>   |  |  | DEGREE  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  |  | 22c. DATE SIGNED <b>1/4/83</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Marco Roffe</b>  |  |  | 22e. ADDRESS <b>Sinai Hospital Baltimore</b>  |  |  |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  |  | 23b. DATE <b>JAN. 5, 1983</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE HEBREW</b>   |  |  | 23d. LOCATION <b>REISTERSTOWN</b> COUNTY <b>BALTO.</b> STATE <b>MD</b>  |  |  |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b> NAME ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 12 1983</b>   |  |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Canine</b>  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



2

18

1

18-18-18

18/18



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Item #1 Film 0577 3/2/83 rc

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8301331

REG. NO.

|  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST <u>Amy</u> MIDDLE <u>Elizabeth</u> LAST <u>RUBRIGHT</u><br><b>BABY GIRL</b> |  |  | 2a. DATE OF DEATH MONTH <u>01</u> DAY <u>02</u> YEAR <u>1983</u> |   |  | 2b. HOUR <u>3:12P</u>   |  |  |  |
| 3. SEX<br><u>FEMALE</u>  |  | 4. RACE<br><u>WHITE</u>  |  | 5. DATE OF BIRTH<br>MONTH <u>DEC.</u> DAY <u>28</u> YEAR <u>1982</u>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. <u>5</u>  |  | IF UNDER 1 YEAR<br>MONTHS <u>5</u> DAYS <u></u> HOURS <u></u> MIN. <u></u> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>MARYLAND</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>BALTIMORE CITY</u> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><u>BALTIMORE</u>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>THE JOHNS HOPKINS HOSPITAL</u> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><u>MARYLAND</u>  |  | 13b. COUNTY<br><u>BALTO.</u>   |  | 13c. CITY OR TOWN<br><u>PARKVILLE</u>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><u>21234 3301 WILLOUGHBY ROAD</u>                   |  |
| 14. FATHER'S NAME<br>FIRST <u>ROONIS</u> MIDDLE <u>A.</u> LAST <u>RUBRIGHT</u>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <u>ELIZABETH</u> MIDDLE <u>C.</u> LAST <u>MCULLERY</u>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <u>NO</u>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |  | 17. INFORMANT<br><u>FAMILY RECORDS</u>  |  |   |  |  |  |

|   |  |   |  |
|---|--|---|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>7690 IMMEDIATE CAUSE (a) <u>Hyaline Membrane Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Extreme Prematurity</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
|---|--|---|--|

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Renal Failure</u>   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><u>-</u>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>-</u>           |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/28</u> 19 <u>82</u> , to <u>1/2</u> 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>1/2</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>G. Karlowicz MD</u>  |  |  |  | DEGREE   |  | 22c. DATE SIGNED<br><u>1/2/83</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>GARY KARLOWICZ</u>  |  |  |  | 22e. ADDRESS<br><u>JOHNS HOPKINS HOSPITAL</u>                                  |  |  |  |

|   |  |                                  |  |  |  |  |  |
|---|--|----------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>BURIAL</u>                           |  | 23b. DATE<br><u>JAN. 5, 1983</u> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>DULANEY VALLEY CEM.</u> |  | 23d. LOCATION<br>CITY OR TOWN <u>BALTO.</u> COUNTY <u>MARYLAND</u> STATE <u></u> |  |
| 24. FUNERAL DIRECTOR<br>NAME <u>EVANS FUNERAL CHAPEL</u> ADDRESS <u>8800 HARFORD R.</u> |  |                                  |  | 25a. DATE REC'D. BY REGISTRAR<br><u>JAN 7 1983</u>               |  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Conner</u>                              |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. Page 3 should be retained by the funeral director. IMPORTANT: If item 21 is not filled in after item 8 shows any injury, or other dramatic event, the medical examiner may be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  | 8 3 0 1 3 3 2  |  |  |  |   |  |
|---|--|---|--|---|--|--|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |   |  |   |  | REG. NO.   |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  | FIRST MIDDLE LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR                                 |  |  |  | 2b. HOUR  |  |
| JAMES E. RUDASILL   |  |   |  |   |  | 01/06/83   |  |  |  | 7:35 PM   |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                  |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS   |  |
| Male  |  | White   |  | MONTH DAY YEAR<br>Oct 7, 1915   |  | 67 YRS.  |  | MONTHS DAYS  |  | HOURS MIN.  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                             |  |  |  |   |  |
| Maryland  |  | U.S.A.  |  |   |  | BALTIMORE CITY MD.   |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| BALTIMORE   |  | THE JOHNS HOPKINS HOSPITAL  |  |   |  | Retired  |  | - -  |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  | 13b. CITY OR TOWN  |  | 13c. STREET ADDRESS  |  |   |  |
| 13a. STATE  |  |   |  |   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  |
| Maryland  |  |   |  |   |  | - -  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME   |  |   |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |  |  |   |  |
| FIRST MIDDLE LAST   |  |   |  | FIRST MIDDLE LAST   |  |  |  |  |  |   |  |
| James G. Rudasill   |  |   |  | Nellie Morgan   |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |  |  |  |   |  |
| Yes   |  |   |  | WW II   |  | 213-05-0614 Michael Rudasill- 3636 Malden Ave. (21211)           |  |  |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:   |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                     |  |
| IMMEDIATE CAUSE (a) Overwhelming Sepsis   |  |   |  |   |  |  |  |  |  |   |  |
| 4439  |  |   |  |   |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |  |  |  |  |   |  |
| (b)   |  |   |  |   |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |  |  |  |  |   |  |
| (c)   |  |   |  |   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |  |   |  |  |  |  |  |   |  |
| Renal Failure / Status Post Aorta Bifurcated Bypass Graft   |  |   |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?   |  |
| 12/2/82   |  |   |  | Peripheral Vascular Disease   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) |  |   |  |
|   |  |   |  | P.M. 19   |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  | 21f. LOCATION  |  |   |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   |  |   |  |  |  | CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/3, 19 83, to 1/6, 19 83, that (I) (we) last saw the deceased alive on 1/6, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE  |  |   |  | DEGREE  |  |  |  | 22c. DATE SIGNED   |  |   |  |
| Villarreal  |  |   |  | MD  |  |  |  | 1/6/87   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e. ADDRESS  |  |  |  |  |  |   |  |
| Villarreal  |  |   |  | Johns Hopkins Hospital  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY                               |  | 23d. LOCATION  |  |   |  |
| Burial  |  |   |  | Jan 10, 1983  |  | Lake View Mem Park   |  | Randalstown, Maryland  |  |   |  |
| 24. FUNERAL DIRECTOR  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR                                    |  | BY REGISTRAR'S SIGNATURE   |  |   |  |
| A. Alan Seitz Funeral Home 3618 Roland Ave.   |  |   |  |   |  | JAN 13 1983  |  | John J. Cahill   |  |   |  |

Burial Jan 10, 1933 Lake View Park Indianapolis, Maryland

11 110

12

1997

113-9-614 Michael Russell - 307 Maiden Ave. (1911)

x

— — —

3630 Kaituma Avenue (1511)

— —

A. 2. 5

## Analysis

2001, 2002

72

Life

•

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (S))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |   |  |                                     |  |                                |  |                                |  |                |  |              |  |
|--|--|--|--|---|--|---|--|-------------------------------------|--|--------------------------------|--|--------------------------------|--|----------------|--|--------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN<br>OF ESTI-<br>MATED |  | MONTH                          |  | DAY                            |  | YEAR           |  | 2b. HOUR     |  |
| WILLIE   |  |  |  |   |  | RUFF  |  | 13                                  |  | 3                              |  | 19                             |  | 83             |  | M            |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)  |  | IF UNDER 1 YR.<br>MONTHS DAYS       |  | IF UNDER 24 HRS.<br>HOURS MIN. |  | 2c. DATE<br>PRONOUNCED<br>DEAD |  | MONTH DAY YEAR |  | 2d. HOUR     |  |
| male   |  | Black  |  | May 3, 1904   |  | 78 YRS.   |  |                                     |  |                                |  | 14                             |  | 19             |  | 10:45<br>a M |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |                                     |  |                                |  |                                |  |                |  |              |  |
| Columbia, S. Car.  |  | USA  |  |   |  | Baltimore City  |  |                                     |  |                                |  |                                |  |                |  |              |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |  |                                     |  |                                |  |                                |  |                |  |              |  |
| Baltimore  |  | 2701 Baker St.   |  | retired   |  |   |  |                                     |  |                                |  |                                |  |                |  |              |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS                 |  |                                |  |                                |  |                |  |              |  |
| Md.  |  |  |  | Balto.  |  |   |  | 2701 Baker St.                      |  |                                |  |                                |  |                |  | 21216        |  |
| 14. FATHER'S NAME<br>FIRST   |  | MIDDLE   |  | LAST  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST   |  | MIDDLE                              |  | LAST                           |  |                                |  |                |  |              |  |
|  |  |  |  |   |  |   |  |                                     |  |                                |  |                                |  |                |  |              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |                                     |  |                                |  |                                |  |                |  |              |  |
| no   |  | 218 01 6151  |  | James Osborne   |  | Columbia, South Car.<br>1923 Barnwell St.   |  |                                     |  |                                |  |                                |  |                |  |              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>4029 IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardiovascular disease<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____   |  | DUE TO, OR AS A CONSEQUENCE OF   |  | DUE TO, OR AS A CONSEQUENCE OF  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |                                     |  |                                |  |                                |  |                |  |              |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |   |  |   |  |                                     |  |                                |  |                                |  |                |  |              |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |                                     |  |                                |  |                                |  |                |  |              |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |                                     |  |                                |  |                                |  |                |  |              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET   |  | CITY OR TOWN  |  | COUNTY                              |  | STATE                          |  |                                |  |                |  |              |  |
| 22a. I certify that I took charge of the remains described above, held an<br>death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |  |  |   |  |   |  |                                     |  |                                |  |                                |  |                |  |              |  |
| ACTUAL<br>SIGNATURE  |  | TITLE (SPECIFY)<br>M.D. Assistant  |  | MEDICAL EXAMINER  |  | DATE<br>SIGNED  |  | 1-4-83                              |  |                                |  |                                |  |                |  |              |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  | Ann M. Dixon, M.D.   |  | ADDRESS   |  | 111 Penn St., Balto., Md. 21201   |  |                                     |  |                                |  |                                |  |                |  |              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN   |  | COUNTY                              |  | STATE                          |  |                                |  |                |  |              |  |
| Burial   |  | 1/10/83  |  | KING MEM. PK.   |  | BALTO., MD.   |  |                                     |  |                                |  |                                |  |                |  |              |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |                                     |  |                                |  |                                |  |                |  |              |  |
| Leroy O. Dyett   |  | 4600 Liberty Hgts. Ave.  |  | JAN 10 1983   |  | John J. Lamer   |  |                                     |  |                                |  |                                |  |                |  |              |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

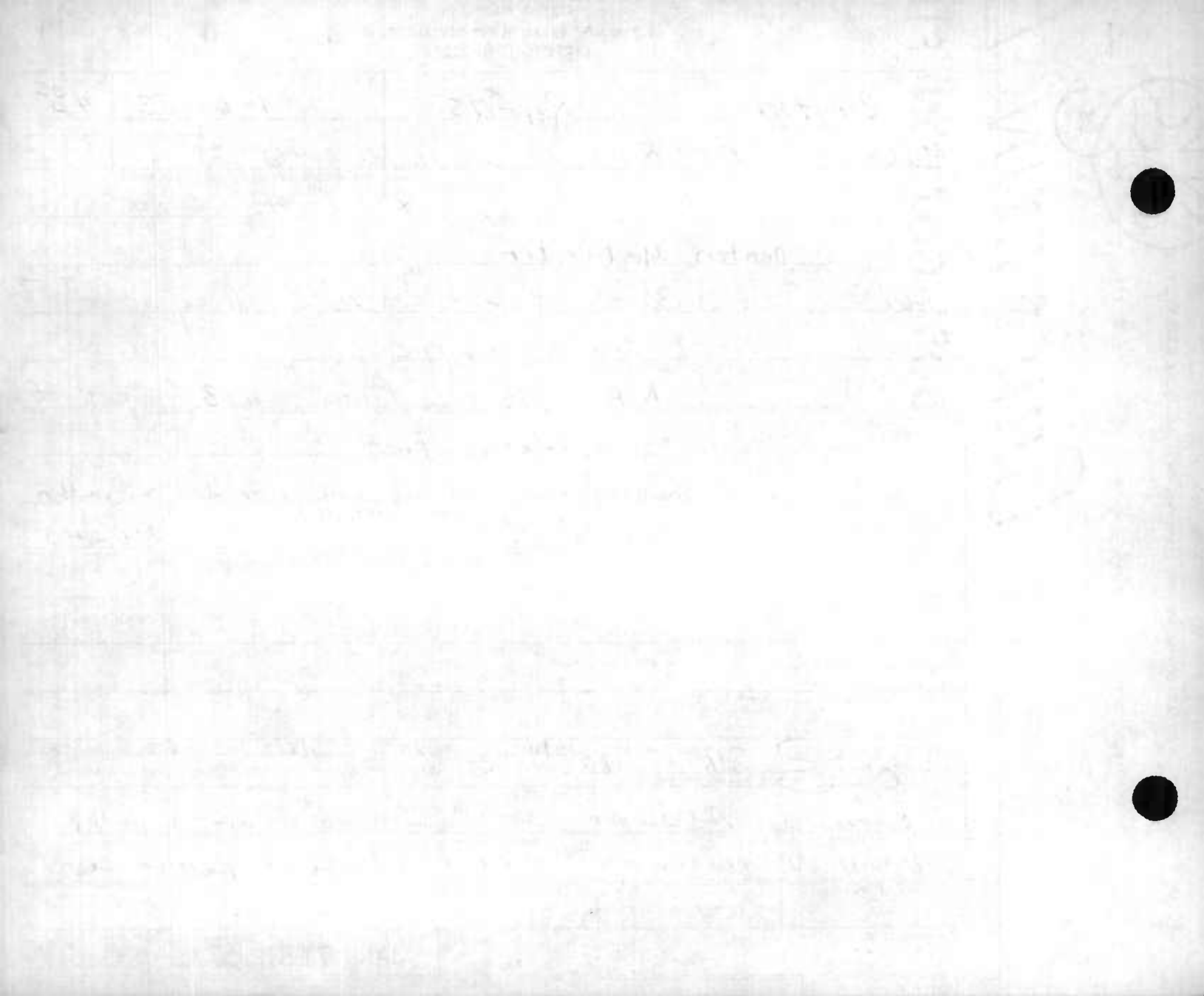
FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |   |  |   |  |
|---|--|---|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Clayton Rufus</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1-6-83</b>                      |   |  | 2b. HOUR<br><b>4<sup>05</sup> A<sup>M</sup></b>  |   |  |   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 3 36</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>46</b> YRS   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Denton Med Center</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE<br><b>Md</b>   |  | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS<br><b>1603 Aisquith St.</b>  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Clarence Rufus</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Maggie Wilson</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>yes</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>   |   | 17. INFORMANT<br><b>Hermine Rufus</b> ADDRESS<br><b>1603 Aisquith St.</b>  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>1629</b> IMMEDIATE CAUSE (a) <b>Cardio-Pulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Small cell carcinoma of lung with liver and spinal cord metastasis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Severe decubiti</b> |  |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>~ 8 months</b><br><b>3-4 months</b>                                     |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |  |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/16</b> , 19 <b>82</b> , to <b>1/6</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1/6</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If yes) (I did not) view the body after death.   |  |   |  |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>David W. McClure MD</b>  |  |   | DEGREE<br><b>MD</b>  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1/6/83</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DAVID W. McClure MD</b>   |  |   | 22e. ADDRESS<br><b>611 S. Charles St. Balto Md. 21230</b>              |   |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>1/11/83</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Zion Cem.</b>                     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Landsdown, Md.</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H</b>   |  |   |  |   | ADDRESS<br><b>1101 E. North Ave.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 7 1983</b>                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conish</b> |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |  |  |   |
|--|---|---|--|--|---|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>WILLIAM F. RUNGE</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 12, 1983</b>                         |  | 2b. HOUR<br><b>9:00A</b>  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 8, 1907</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>913 E. 37th St. 21218</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Police Sgt.</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Balto. City</b>   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |   |   | 13b. CITY OR TOWN<br><b>Baltimore</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Otto Runge</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Katharine Schwindinger</b>         |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>220 46 2042</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Constance Murrell, Balto., MD</b>                |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>metastatic lung cancer</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |   |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>6 MONTHS</b>                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>CHRONIC OBSTRUCTIVE LUNG DISEASE</b>  |   |   |  |  |   |
| 19a. DATE OF OPERATION<br><b>—</b>   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)    |  |  |   |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>December, 1982</b> to <b>present</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>4 JANUARY</b> 19 <b>83</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |   |   |  |  |   |
| 22b. SIGNATURE<br><b>Dolores M. Purnell</b>  |   | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>13 JAN 83</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Dolores M. Purnell, M. D.</b>  |   | 22e. ADDRESS<br><b>Union Memorial Hospital, Balto., MD</b>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>1/15/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn</b>                                |   |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Balto., MD</b>   |   | 23e. COUNTY<br><b>MD</b>  |  |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b>   |   | 24b. ADDRESS<br><b>4905 York Road Balto., MD 21212</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 13 1983</b>                                  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>  |   |   |  |  |   |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



Dr. Dolores M. Purnell, M.D., Union Memorial Hospital, Baltimore, MD.  
Henry W. Jenkins & Sons Co., Baltimore, MD.  
Burial

No. 220 48 2042 Mr. Constance Purnell, Baltimore, MD.

Run 5 Caroline Administration

Baltimore

Administration

Administration

Administration

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 01336

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JAMES L. Russell</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>1-24-83</b> |   |  | 2b. HOUR <b>15</b><br>MIN. <b>6A</b>   |   |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>6-2-1904</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.                                    |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY - MD.</b>                  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Deaton Med Center</b>                          |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CARPENTER</b> |   |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CONSTRUCTION</b>  |  | 13a. STATE<br><b>MD.</b>   |  | 13b. COUNTY<br><b>—</b>   |  | 13c. CITY OR TOWN<br><b>BALTO.</b>   |   |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>719 N. CHESTER ST.</b>   |  | 13f. ZIP CODE<br><b>21205</b>   |  |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>JAMES RUSSELL</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>ANNIE V. EDWARDS</b>   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>578-18-3132</b>   |  | 17. INFORMANT<br>ADDRESS <b>Mrs. Peggy Allen, 1238 S. Grantley St. 21229</b>  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1419 IMMEDIATE CAUSE (a) Respiratory Arrest</b>  |  |  |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Cancer of Tongue</b>   |  |  |  |   |  |  | <b>8 months</b>                                 |
| (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>   |  |  |  |   |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a   |  |  |  |   |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |   |  |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |   |
| 22b. SIGNATURE<br><b>Robert A. Barthele</b>   |  | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><b>1/24/83</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert A. Barthele</b>  |  | 22e. ADDRESS<br><b>611 South Charles Street BALTO. MD.</b>   |  |   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE<br><b>1-26-82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b>                      |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>John J. Gough - 2334 Jefferson St.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 25 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Gough</b>  |  |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

BP \_\_\_\_\_



NAME

No

or Hill



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP 548

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| Items #25a-24 Film G575 1/31/83 rc   |  |                      |  |   |  |   |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |       |  |   |  |  |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |  |  |  |  |  |  |  |  | REG. NO. 83 01337 |  |  |  |  |  |  |  |  |  |
|--|--|----------------------|--|---|--|---|--|--|--|--|--|---|--|-------|--|---|--|--|--|---|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Raymond Russell</b>   |  |                      |  |   |  |   |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>19</b> |  |   |  |       |  |   |  |  |  | 2b. HOUR <b>1:51</b>                    |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>Black</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>12 21 30</b>  |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY) <b>52</b> YRS. |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   |  | 7c. DATE PRONOUNCED DEAD <b>1 19 1983</b>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>      |  |       |  |   |  |  |  |   |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| 7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>   |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |   |  |       |  |   |  |  |  |   |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2426 Etting St.</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                               |  |       |  |   |  |  |  |   |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| 13a. STATE <b>Md.</b>  |  |                      |  | 13b. COUNTY   |  | 13c. CITY OR TOWN <b>Balto.</b>                   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS <b>2426 Etting St.</b>   |  |   |  | 21217 |  |   |  |  |  |   |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Vernon Russell</b>   |  |                      |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Virginia Bailey</b>  |  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>  |  |  |  | 16b. SOCIAL SECURITY NO. <b>220-24-3064</b>                     |  |       |  | 17. INFORMANT ADDRESS <b>2426 Etting St. Virginia Russell Balto., Md. 21217</b>     |  |  |  |   |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic Alcoholism</b><br><b>3030</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>DUE TO, OR AS A CONSEQUENCE OF  |  |                      |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |       |  |   |  |  |  |   |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |                      |  |   |  |   |  |  |  |  |  |   |  |       |  |   |  |  |  |   |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |  |  |  |   |  |       |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |   |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |  |  |   |  |       |  |   |  |  |  |   |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |       |  |   |  |  |  |   |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |  |   |  |   |  |  |  |  |  |   |  |       |  |   |  |  |  |   |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>H R Guard</b>  |  |                      |  | M.D. <b>Assistant</b>   |  |   |  | MEDICAL EXAMINER   |  |  |  | DATE SIGNED <b>1/20/83</b>                                      |  |       |  |   |  |  |  |   |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>   |  |                      |  | ADDRESS <b>111 Penn St., Balto., Md.</b>  |  |   |  |  |  |  |  |   |  |       |  |   |  |  |  |   |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>Burial Removal</b>  |  |                      |  | 23b. DATE <b>1/25/83</b>  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cem</b>   |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b> |  |       |  |   |  |  |  |   |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm. Brown Funeral Home</b>   |  |                      |  | ADDRESS <b>1206 W. North Ave. Balto., Md.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 28 1983</b>   |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>                |  |       |  |   |  |  |  |   |  |  |  |  |  |  |  |  |  |                   |  |  |  |  |  |  |  |  |  |



93074 NO 110

NO 110



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 3 3 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |  |  |  |
|--|---|---|--|--|--|
| 1. DECEASED NAME<br>FIRST MARY MIDDLE BROOKE LAST RUTLEY   |   |   | 2a. DATE OF DEATH<br>MONTH 11 DAY 13 YEAR 83                                 |  | 2b. HOUR<br>2:37 PM  |
| 3. SEX<br>F  | 4. RACE<br>CAUCASIAN  | 5. DATE OF BIRTH<br>MONTH 1 DAY 9 YEAR 29   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>54  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>US  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO CITY MD                        |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CLERICAL | 12b. KIND OF BUSINESS OR INDUSTRY<br>GOVT. MD                                  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE MD 13c. CITY OR TOWN BALTO  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 13e. STREET ADDRESS<br>6840 WESTRIDGE RD 21207                               |  |  |
| 14. FATHER'S NAME<br>FIRST Fetter H. MIDDLE Rose LAST  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST Mary S. MIDDLE Rose LAST Swerdloff  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) No  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>189-24-5341  | 17. INFORMANT<br>Mr. Kimberly Ashley Balto. MD.<br>6840 Westridge Rd. 21207  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>1629 IMMEDIATE CAUSE (a) METASTATIC ADENOCARCINOMA LUNG<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/13/83 to 11/13/83, that (I) (we) lost the deceased alive on 11/13/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If yes) (did) (did not) view the body after death.   |   |   |  |  |  |
| 22b. SIGNATURE<br>LORING BYERS MD  |   | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>11/13/83   |  |
| 22d. FUNERAL HOME'S NAME (TYPE OR PRINT)<br>LEONARD LICHTENBERG  |   | 22e. ADDRESS<br>2435 W BALDWIN BL; BALTO 21205  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |   | 23b. DATE<br>1-15-83  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadow Branch                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Westminster Carroll Maryland   |
| 24. FUNERAL DIRECTOR<br>NAME Loring Byers ADDRESS Randallstown, MD. 21133  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 17 1983                                 |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Ganiel   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

1. Name of the person  
2. Address  
3. Date of birth  
4. Sex  
5. Religion  
6. Caste  
7. Education  
8. Occupation  
9. Marital status  
10. Date of marriage  
11. Name of spouse  
12. Name of children  
13. Name of parents  
14. Name of grandparents  
15. Name of siblings  
16. Name of other relatives  
17. Name of friends  
18. Name of neighbors  
19. Name of other persons  
20. Name of other persons

Signature of the person

1. Name of the person  
2. Address  
3. Date of birth  
4. Sex  
5. Religion  
6. Caste  
7. Education  
8. Occupation  
9. Marital status  
10. Date of marriage  
11. Name of spouse  
12. Name of children  
13. Name of parents  
14. Name of grandparents  
15. Name of siblings  
16. Name of other relatives  
17. Name of friends  
18. Name of neighbors  
19. Name of other persons  
20. Name of other persons

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8301339

1- FOR  
STATE  
REGISTRAR

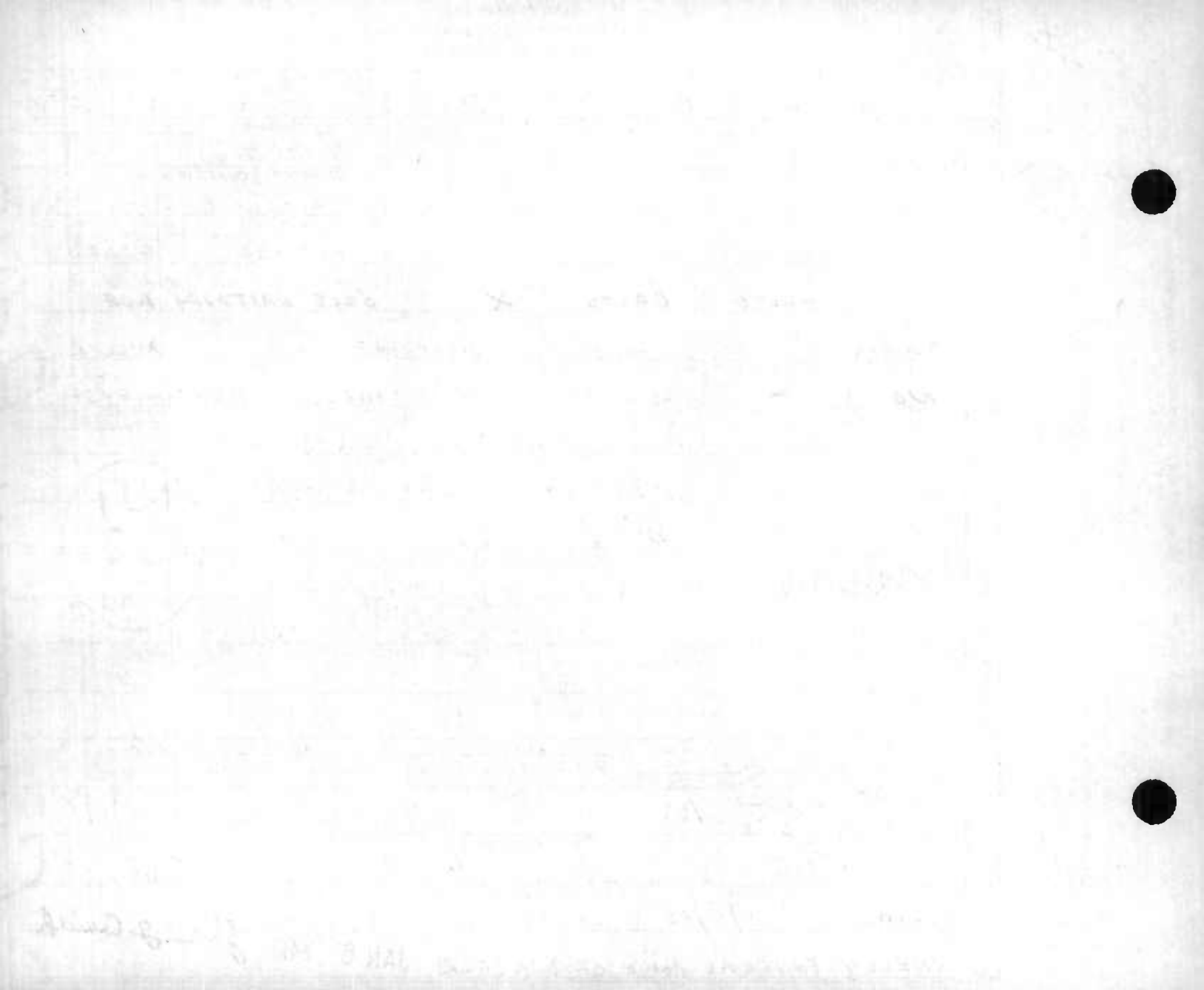
REG. NO.

|   |  |  |   |   |  |  |  |
|---|--|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIAM B. RYNES</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1 1 83</b> |   |  | 2b. HOUR<br><b>2:00 PM</b>   |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>W</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 3 11</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE CITY HOSPITALS</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>GUARD</b>   |  |  |   |   |  |  |  |
| 13a. STATE<br><b>MD.</b>  |  | 13b. COUNTY<br><b>BALTO</b>  |   | 13c. CITY OR TOWN<br><b>BALTO</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13e. STREET ADDRESS<br><b>21206 5205 EASTBURY AVE</b>   |  |  |   |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>THOMAS RYNES</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>JOSEPHINE MILLER</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-12-1281</b>   |   | 17. INFORMANT ADDRESS<br><b>MAUREEN SCHELLER 7323 CONLEY ST 21224</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio respiratory arrest/Failure</b><br>4409<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>severe Atherosclerosis, Diabetes.</b> 15 yr.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>congestive heart failure.</b> 15 yr.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Dissection, Bilateral leg amputation.</b> |  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION<br><b>None</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/1/82</b> to <b>1/1/83</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/1</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>B. Moffatt</b>   |  |  |   | DEGREE  |  | 22c. DATE SIGNED<br><b>1/1/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>B. Moffatt</b>  |  |  |   | 22e. ADDRESS<br><b>Baltimore City Hospital.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>1/5/83</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO BALTO</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>CONNELLY FUNERAL HOME OF DUNDALK</b>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>JAN 6 1983</b>   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8301340

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |  |  |   |  |  |  |
|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>John Sachs     |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1/24/83 |  |  | 2b. HOUR<br>9:40 AM   |  |  |  |
| 3. SEX<br>male  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JUNE 13, 1897  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS.                                  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MERCY HOSPITAL |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>UNKNOWN |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>UNKNOWN |  |

|  |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>808 ST. PAUL ST. #21202 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>UNKNOWN                          |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>UNKNOWN                                |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-54-6628T |  | 17. INFORMANT<br>HEBREW BURIAL & SOC. SER. SOCIETY<br>326 ST. PAUL ST. BALTO., MD 21202 |  |   |  |  |  |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>y12 |  |
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|--|--|--|--|--|--|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>Chronic Renal failure, Probable Sepsis |  |  |  |  |  |  |  |  |  |
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| 19a. DATE OF OPERATION<br>— |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>— |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
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|---|--|--|--|---|--|--|--|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>— |  |  |  |
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| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE |  |
|--|--|--|--|---|--|

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| 22a. I certify that (I) (this hospital) attended the deceased from 1/12, 1983, to 1/24/83, that (I) (we) last saw the deceased alive on 1/24, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
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|                                 |  |  |  |              |  |                             |  |
|---------------------------------|--|--|--|--------------|--|-----------------------------|--|
| 22b. SIGNATURE<br>John Margolis |  |  |  | DEGREE<br>MD |  | 22c. DATE SIGNED<br>1/24/83 |  |
|---------------------------------|--|--|--|--------------|--|-----------------------------|--|

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|--|--|--|--|---|--|--|--|
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John MARGOLIS |  |  |  | 22e. ADDRESS<br>Mercy Hospital 304 St. Paul Pl. 21201 |  |  |  |
|--|--|--|--|---|--|--|--|

|   |  |                            |  |  |  |  |  |
|---|--|----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL |  | 23b. DATE<br>JAN. 25, 1983 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BALTIMORE HEBREW |  | 23d. LOCATION<br>BALTIMORE COUNTY MARYLAND |  |
|---|--|----------------------------|--|--|--|--|--|

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| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215 |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 1 1983 |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Connel |  |
|---|--|--|--|---|--|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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ORDER NO. 100-100000-100000

DATE OF ORDER

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

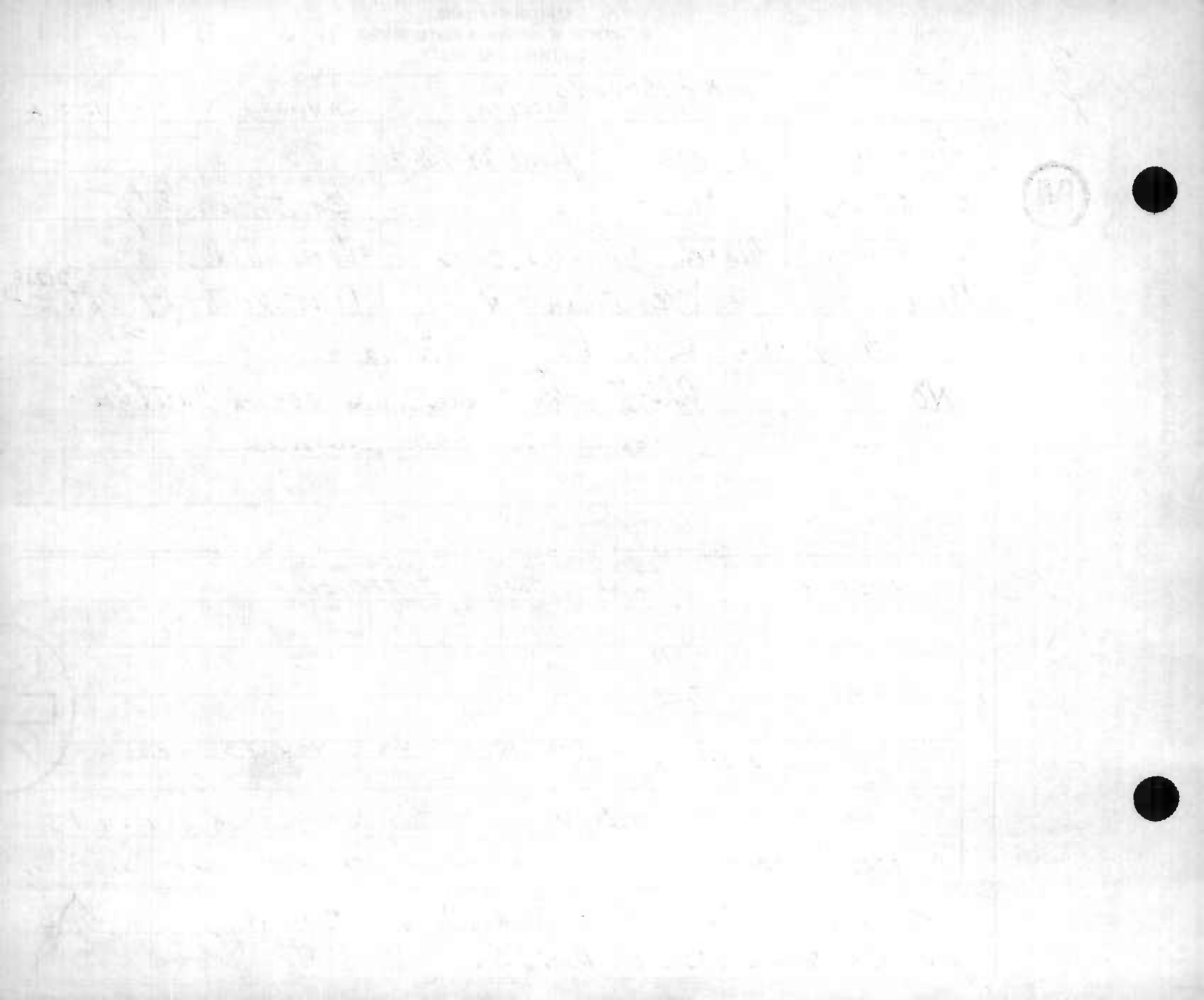
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 of this certificate should be detached for use as the burial-transit permit. Then please remove corbopen, pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 3 0 1 3 4 1  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ANNIE AKA Brooks SALEETA</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JANUARY 23 1983</b>   |  | 2b. HOUR<br><b>12:38 AM</b>   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Negro</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>June 28 1904</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS<br><b>78</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>North Charles Gen.</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Name makes</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Alexander Brooks</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Edna</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS<br><b>220-30-4445 Lucille Russ 2222 W. North Ave.</b>                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b><br><b>4280</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____   |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>ANEMIA</b> <b>URINARY TRACT INFECTION</b>  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JAN - 15</b> , 19 <b>83</b> , to <b>JAN. 23</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>JAN. 23</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>C. VERGARA - SOARES</b>   |  |   |  | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>1-23-83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. VERGARA - SOARES</b>  |  |   |  | 22e. ADDRESS<br><b>N. CHARLES GEN. HOSP. BALT. MD. 21248</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/26/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Wt. Calvary Cem.</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Joseph L. Russ 2222 W. North Ave.</b>   |  |   |  | 25a. DATE RECD. BY REGISTRAR<br><b>JAN 31 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John L. Smith</b>  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 3 4 2

REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>LILLIAN M. SANDS   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JANUARY 21, 1983   |  | 2b. HOUR<br>4:50 AM  |
| 3. SEX<br>FEMALE   | 4. RACE<br>WHITE  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 10 1903  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE MD.   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>CHURCH HOME HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED                     |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br>MARYLAND  | 13b. COUNTY   | 13c. CITY OR TOWN<br>BALTIMORE  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>612 S. LUXERNE AVE. 21224                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>BENJAMIN PARLETT   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>RACHEL TURPIN  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)<br>NO  |   | 16b. SOCIAL SECURITY NO.<br>219 10 8681A  |   | 17. INFORMANT<br>ADDRESS<br>ELSIE SIWA 9202 RAVENWOOD RD #37                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4289 IMMEDIATE CAUSE (a) CARDIAC FAILURE  |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |   |   |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)   |   |   |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 30, 19 82, to JANUARY 21, 19 83, that (I) (we) last saw the deceased alive on JANUARY 21, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If signed by doctor, view the body after death) |   |   |   |  |  |
| 22b. SIGNATURE<br>Paul E. Gormley  |   | DEGREE<br>MD  |   | 22c. DATE SIGNED<br>1/21/83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PAUL E. GORMLEY, M.D.   |   | 22e. ADDRESS<br>CHURCH HOSPITAL<br>100 NORTH BROADWAY, BALTIMORE, MD. 21231   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK BY)  | 23b. DATE<br>1/24/1983  | 23c. NAME OF CEMETERY OR CREMATORY<br>GARDEN OF FAITHS  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MD.                          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>RAYMOND H. KACZOROWSKI   |   | ADDRESS<br>2525 FLEET ST.   |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 25 1983   |  |
|  |   | 25b. REGISTRAR'S SIGNATURE<br>James J. Connel   |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrator, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   | REG. NO.  |  |
|--|--|---|--|---|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   | 83 01343  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>WILLIAM A. SATTERFIELD   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>JAN. 21, 1983                           |   |  |
| 3. SEX<br>M  |  | 4. RACE<br>W  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5/26/16                                 |   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS.   |  | 7. UNDER 1 YEAR<br>MONTHS DAYS<br>HOURS MIN.  |  | 8. UNDER 24 HRS<br>HOURS MIN.   |   |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>W. VA.   |  | 10. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. CITY MD.                      |   |  |
| 12. CITY OR TOWN OF DEATH<br>BALTO.  |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2205 WESTFIELD |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>DISABLED   |   |  |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE M.D. 13b. COUNTY 13c. CITY OR TOWN BALTO.  |  | 16. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                              |  | 17. STREET ADDRESS<br>2205 WESTFIELD RD 21222                                 |   |  |
| 18. FATHER'S NAME<br>FIRST MIDDLE LAST<br>CLAY SATTERFIELD   |  | 19. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ALLIE HUFFMAN  |  | 20. ADDRESS<br>1815 STEVEN EDEWOOD MD   |   |  |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>UNK   |  | 22. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>23603 9680   |  | 23. INFORMANT<br>JERRY SATTERFIELD  |   |  |
| 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4100 <i>Colony Infection</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Emphysema obstructive and retentive</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cor Pulmonale - Hypertension</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10y. |  |   |  |   | 25. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):   |  |
| 26. DATE OF OPERATION<br>NONE  |  | 27. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 28. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   |  |
| 29. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 30. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |
| 32. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 33. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 34. LOCATION<br>CITY OR TOWN COUNTY STATE                                     |   |  |
| 35. I certify that (I) (this hospital) attended the deceased from 1970 to 1/21/83, that (I) (we) last saw the deceased alive on 1/21/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   | 36. SIGNATURE<br>J. E. T. HOPKINS MD<br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/><br>27b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. E. T. HOPKINS<br>27c. ADDRESS<br>205 W. Samuel St 21217 |  |
| 37. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 38. DATE<br>1/24/83   |  | 39. NAME OF CEMETERY OR CREMATORY<br>MEADOWRIDGE                              |   |  |
| 40. FUNERAL DIRECTOR<br>NAME<br>J. G. CONNELLY   |  | 41. ADDRESS<br>300 MALE   |  | 42. DATE REC'D. BY REGISTRAR<br>JAN 25 1983                                   |   |  |
| 43. REGISTRAR'S SIGNATURE<br>J. G. Connelly  |  | 44. REGISTRAR'S SIGNATURE<br>J. G. Connelly   |  |   |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove the carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to final disposition, cremation, or entombment.

IMPORTANT: If item 21, immediate or item 18 shows injury, or other traumatic cause, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| ITEM 19a&b Film 576   |  |  |  | STATE OF MARYLAND  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1 - STATE 2-10-83 cn  |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |
| REGISTRAR   |  |  |  | CERTIFICATE OF DEATH   |  |  |  |
| 1. DECEASED NAME  |  |  |  | 2a. DATE OF DEATH  |  |  |  |
| FIRST MIDDLE LAST   |  |  |  | MONTH DAY YEAR   |  |  |  |
| CLARENCE B SAVAGE   |  |  |  | JANUARY 15, 1983   |  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE   |  |
| Male  |  | White  |  | MONTH DAY YEAR   |  | 73 YRS.  |  |
| 7a. BIRTHPLACE  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| Pennsylvania  |  | USA  |  | NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                               |  | BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION                |  | 12a. USUAL OCCUPATION  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| BALTIMORE   |  | JOHNS HOPKINS HOSPITAL 21205   |  | Retired  |  |  |  |
| 13a. USUAL RESIDENCE  |  |  |  | 13b. INSIDE CITY LIMITS?   |  |  |  |
| STATE CITY OR TOWN  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| Maryland Baltimore  |  |  |  | 13c. STREET ADDRESS  |  |  |  |
|   |  |  |  | 620 E. 31st Street 21218   |  |  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST  |  |  |  |  |  |
| William Savage  |  | Anna M. Seese  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |  |  |
| No  |  | 201-01-8081  |  | Mrs. Janet Cornett 620 E. 31 St. 21218   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i>   |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Staph sepsis</i>  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>prostatic valve placement.</i>  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
| 1973  |  | Unknown currenty   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
|   |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3 Jan</i> , 19 <i>83</i> , to <i>15 Jan</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>15 Jan</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| <i>[Signature]</i>  |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 1/15/83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |  |  |  |
| Belman  |  |  |  | JHK  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |
| Burial  |  | 1/20/83  |  | Cedar Hill Cem.  |  | Glen Burnie Maryland   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS   |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |  |  |
| A. Alan Seitz, Jr. 3818 Roland Ave. 21211   |  |  |  | JAN 21 1983 <i>[Signature]</i>   |  |  |  |



|              |            |   |    |    |                          |
|--------------|------------|---|----|----|--------------------------|
| Male         | White      | 2 | 03 | 03 | 20                       |
| Pennsylvania | USA        | x |    |    |                          |
| Retired      | Retired    |   |    |    |                          |
| Karlsruhe    | Baltimore  | x |    |    | 620 E. 31st Street 21218 |
| William      | Anna       |   |    |    | 620 E. 31st Street 21218 |
| No           | 601-01-081 |   |    |    | 620 E. 31st Street 21218 |

Initial 1/20/53 Cedar Hill Cem. Glen Burnie Md. Maryland  
A. Alan Selts, Jr. 3018 Roland Ave. 21211

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |        |   |  |  |                                    |  |  |   |  |  |
|--|--------|---|--|--|------------------------------------|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |        |   | 2a. DATE OF DEATH  |  |                                    | 2b. HOUR   |  |   |  |  |
| FIRST  | MIDDLE | LAST  | MONTH  | DAY  | YEAR                               | MONTH  | DAY  | YEAR  |  |  |
| ELMER JOHN SCANLON   |        |   | JANUARY 4, 1983  |  |                                    | 12:15 A.M.   |  |   |  |  |
| 3. SEX   |        | 4. RACE   |  | 5. DATE OF BIRTH   |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. IF UNDER 1 YEAR  |  |  |
| MALE   |        | WHITE   |  | MONTH DAY YEAR<br>APRIL 8, 1919  |                                    | 62 YRS.  |  | MONTHS DAYS HOURS MIN.  |  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |        | 9. CITIZEN OF WHAT COUNTRY?   |  | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 11. BALTIMORE CITY OR COUNTY OF DEATH  |  |   |  |  |
| BALTO., MD.  |        | U.S.A.  |  |  |                                    | BALTIMORE CITY MD.   |  |   |  |  |
| 12. CITY OR TOWN OF DEATH  |        | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |                                    | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                |  | 15. KIND OF BUSINESS OR INDUSTRY                                  |  |  |
| BALTIMORE  |        | CHURCH HOSPITAL, INC.   |  |  |                                    | CARPENTER  |  | CONSTRUCTION  |  |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |        |   | 17. INSIDE CITY LIMITS?  |  |                                    | 18. STREET ADDRESS   |  |   |  |  |
| 13a. STATE<br>MARYLAND   |        |   | 13b. COUNTY  |  |                                    | 13c. CITY OR TOWN<br>BALTIMORE   |  |   | 13d. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME  |        |   | 15. MOTHER'S MAIDEN NAME   |  |                                    |  |  |   |  |  |
| FIRST MIDDLE LAST<br>DANIEL JOHN SCANLON   |        |   | FIRST MIDDLE LAST<br>EDITH EIDER                                       |  |                                    |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |        |   | 16b. SOCIAL SECURITY NO.   |  |                                    | 17. INFORMANT  |  |   | ADDRESS  |  |
| NO   |        |   | 212.12.5825  |  |                                    | ELIZABETH ANN SCANLON  |  |   | SAME AS 13e.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFRACTION<br>4254 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which } (b) CARDIO MYOPATHY<br>gave rise to immediate }<br>cause (a), stating the }<br>underlying cause lost. }<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE |        |   |  |  |                                    |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10  |        |   |  |  |                                    |  |  |   |  |  |
| 19a. DATE OF OPERATION   |        |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |                                    | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |  |  |
|  |        |   |  |  |                                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |        |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |        |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |
|  |        |   |  |  |                                    |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from JANUARY 12/29 82 to JANUARY 4, 19 83, that (I) (we) lost<br>saw the deceased alive on JANUARY 4, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |        |   |  |  |                                    |  |  |   |  |  |
| 22b. SIGNATURE   |        |   | DEGREE   |  |                                    | 22c. DATE SIGNED   |  |   |  |  |
| ATAOLLAH NAZEMI M.D.   |        |   |  |  |                                    | 11/4/83  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |        |   | 22e. ADDRESS   |  |                                    |  |  |   |  |  |
| ATAOLLAH NAZEMI M.D.   |        |   | CHURCH HOSPITAL CORPORATION  |  |                                    |  |  |   |  |  |
|  |        |   | 100 N. BROADWAY BALTIMORE, MARYLAND 21231                              |  |                                    |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |        |   | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |   |  |  |
| CREMATION  |        |   | 1/4/1983   |  | GREEN MOUNT CREMATORY              |  | BALTIMORE MD.                              |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |        |   |  |  | 25a. DATE REC'D. BY REGISTRAR      |  | 25b. REGISTRAR'S SIGNATURE                 |   |  |  |
| WALTER BROOKS BRADLEY, INC., DUNDALK, MD. 21222  |        |   |  |  | 'JAN 6 1983                        |  | John J. Canish                             |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 2 and 3 should be detached and retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal autopsy may be required and the medicolegal autopsy report should be attached to this certificate.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |  |  |   |  |                             |
|---|--|---|--|---|--|--|--|---|--|-----------------------------|
| <div style="text-align: right;">8 3 0 1 3 4 6</div> <div style="text-align: center;"> <b>CERTIFICATE OF DEATH</b><br/>           REG. NO.         </div>  |  |   |  |   |  |  |  |   |  |                             |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Humphrey P Scannell</b>   |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1 7 83</b>                |  |  |   |  | 2b. HOUR<br><b>745 A.M.</b> |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>3 6 01</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b>   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br><b>YRS.</b>   |  |                             |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                            |  |   |  |                             |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Railway express</b>      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>   |  |                             |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2818 Beechland Ave 21214</b>  |  |                             |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Humphrey Scannell</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Ellen Lynch</b> |  |  |   |  |                             |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>705-01-7549</b>  |  | 17. INFORMANT ADDRESS<br><b>John H. Scannell - 816 Reverdy Rd. - 21212</b>  |  |  |  |   |  |                             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>4275</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |  |  |   |  |                             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Aspiration pneumonia, Ascites, Cirrhosis</b>  |  |   |  |   |  |  |  |   |  |                             |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                             |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |   |  |                             |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |                             |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>NOV 26</b> , 19 <b>82</b> , to <b>Jan 7</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>Jan 7</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |   |  |                             |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  |   |  | DEGREE  |  |  |  | 22c. DATE SIGNED<br><b>1/7/83</b>   |  |                             |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Donald M. Lai</b>   |  |   |  | 22e. ADDRESS<br><b>Mercy Hospital</b>   |  |  |  |   |  |                             |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1-10-83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith Cem.</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>                                 |  |   |  |                             |
| 24. FUNERAL DIRECTOR NAME<br><b>John C. Miller Inc-6415</b>   |  |   |  | ADDRESS<br><b>Belair Rd. - 21206</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 10 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |                             |

BP

18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200

201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300

301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400

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801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbo-papers. Page 1 and 2 should be filed with the medical examiner's death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  | REG. NO. 83 01347  |  |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |   |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>IRWIN W. SCHEELER</b>  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 21 83</b>   |  | 2b. HOUR<br><b>3<sup>00</sup> P.M.</b>   |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 12 05</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                     |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY</b> MD.                                  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Balto. Gen. Hosp.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Press Operator</b>       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Printing</b>                                 |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>---</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1446 Boyle St. Balto. Md. 21230</b>                        |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John E. Scheeler</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emma --- Korb</b>   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>212-09-9667</b>  |  | 17. INFORMANT ADDRESS<br><b>Mrs. Mildred A. Scheeler, Same as above</b>                         |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>acute respiratory distress syndrome, mucous plugging</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pneumonia</b><br>7 <b>4860</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>arteriosclerotic cardiovascular disease</b>   |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)                  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/9 1983</b> to <b>1/21 1983</b> , that (I) (we) last saw the deceased alive on <b>1/21/83</b> 19 <b>---</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Karen Newton</b>  |  |   |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><b>1/21/83</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KAREN NEWTON</b>   |  |   |  | 22e. ADDRESS<br><b>S. Balto. Gen'l</b>  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   |  | 23b. DATE<br><b>Jan. 25, 1983</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>                                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>              |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>McCurly Funeral Home, 130 E. Fort Ave. Balto. Md.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 24 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Lander</b>   |  |  |  |  |  |

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1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |   |  |
|---|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BERTHA</b>   |  | FIRST <b>SCHERR</b>  |  | LAST   |  | 2a. DATE OF DEATH MONTH <b>01</b> DAY <b>26</b> YEAR <b>83</b>   |  | 2b. HOUR <b>11:15</b>   |  |
| 3. SEX <b>FEMALE</b>  |  | 4. RACE <b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH <b>10</b> DAY <b>16</b> YEAR <b>1895</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> <b>8XX</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTO.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>BALTO.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LEVINDALE</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>                         |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>  |  |
| 13a. STATE <b>MARYLAND</b>  |  | 13b. COUNTY <b>BALTO.</b>  |  | 13c. CITY OR TOWN <b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>XX</b> |  | 13e. STREET ADDRESS <b>3218 MIDFIELD RD.</b> #21208   |  |
| 14. FATHER'S NAME FIRST <b>BERNARD</b> MIDDLE <b>DAVID</b> LAST <b>SMITH</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>SARA</b> MIDDLE <b>WEINER</b> LAST   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO. <b>216-52-6450</b>  |  | 17. INFORMANT <b>MRS. NORMA SCHAPIRO</b>   |  |  |  | 21208   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4292 IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immed.</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>CEREBROVASCULAR ACCIDENT, INTRACRANIAL BLEED</b>   |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                 |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                     |  |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>[Signature]</b>   |  |  |  | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  |  | 22c. DATE SIGNED <b>01-26-83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>B. ZAWWIN</b>  |  |  |  | 22e. ADDRESS <b>LEVINDALE GERIATRIC CTR BALTIMORE 21215</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  | 23b. DATE <b>JAN. 27, 1983</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>HAR ZION TIFERETH ISRAEL</b>   |  | 23d. LOCATION CITY OR TOWN <b>ROSEDALE BALTO.</b> ST MD  |  |   |  |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b><br>NAME ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 1 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |   |  |

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MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STANDARD

100% COTTON

MADE IN U.S.A.

NO



DIFFER

20% COTTON



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

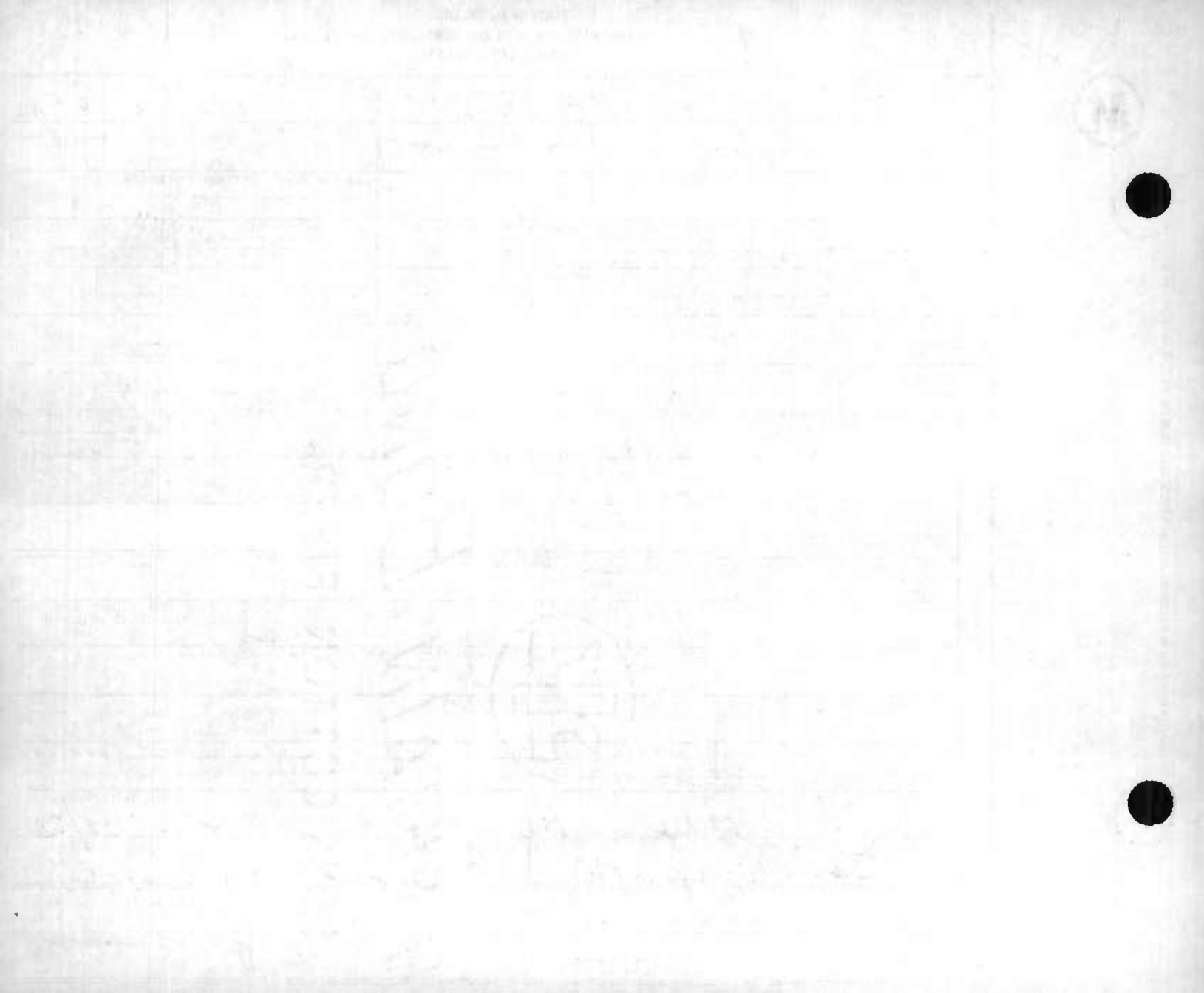
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |   |   |   |
|--|--|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CARMELA TERESE SCHLERETH</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1/28/83</b>                        |   | 2b. HOUR<br><b>9<sup>15</sup> A.M.</b>  |   |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 20 1935</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>47</b><br>YRS   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE, MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD</b>   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE CITY</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE CITY HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>GEN. CLERICAL</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AUTO. WHSE.</b>   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>  |  |   | 13b. COUNTY<br><b>BALTIMORE</b>   | 13c. CITY OR TOWN<br><b>EDGEHURST</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>PHILIP RANIERI</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>JOSEPHINE TROVATO</b> |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>216.30.8889</b>  |   | 17. INFORMANT ADDRESS<br><b>CRAIG M. DUDA 11859 OLD COLUMBIA PIKE 20904</b>   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1749 IMMEDIATE CAUSE (a) Cardiopulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>(b) Metastatic Breast Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>(c)</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 months</b> |  |   |   |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):   |  |   |   |   |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/27</b> 19 <b>83</b> to <b>1/28</b> 19 <b>83</b> that (I) (we) lost<br>saw the deceased alive on <b>1/28</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above; (I) (we) (did) (did not) view the body after death.     |  |   |   |   |   |   |
| 22b. SIGNATURE<br><b>John R. Wittmann MD</b>   |  |   |   | 22c. DATE SIGNED<br><b>1/28/83</b>  |   | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John R. Wittmann MD</b>   |
| 22e. ADDRESS<br><b>Baltimore City Hospital</b>   |  |   |   | 22f. DATE REC'D. BY REGISTRAR 22g. REGISTRAR'S SIGNATURE<br><b>FEB 1 1983</b>   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>2/1/1983</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MOST HOLY REDEEMER</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY, MD</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WALTER BROOKS BRADLEY, INC., DUNDALK, MD</b>  |  |   |   | 25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>FEB 1 1983</b>  |   |   |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death has been ascertained. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the next of kin, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B, then any injury, or other traumatic event, the medical examiner must be notified of.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |   |  |  |  |   |  |  |  |
|--|--|---|---|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |   |   | REG. NO.   |  |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Charles W. SCHMITT   |  |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>January 23, 1983                       |  |  | 2b. HOUR<br>1:00 PM                               |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>Oct. 8, 1907   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS.                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.         |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                    |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>409 N. Kenwood Avenue |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Labor         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Machine Shop |  |  |  |
| 13a. STATE<br>Maryland   |  |   |   |   | 13b. COUNTY<br>0-----  |  | 13c. CITY OR TOWN<br>Baltimore   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |  |
| 14. FATHER'S NAME (TYPE OR PRINT)<br>Casper Schmitt  |  |   |   |   | 15. MOTHER'S MAIDEN NAME (TYPE OR PRINT)<br>Rosa Olricheska                |  |  |   |  | 13e. STREET ADDRESS<br>409 N. Kenwood Avenue   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  |   |   |   | 16b. SOCIAL SECURITY NO.<br>-----  |  | 17. INFORMANT ADDRESS<br>Cliff Jackson 11 Lydia Ct. 21208                            |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>1629 IMMEDIATE CAUSE (a) <i>Ca. Lung &amp; Metastasis</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>b) _____<br>c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><i>Blindness -</i>   |  |   |   |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION STREET   |  | CITY OR TOWN                                      |  | COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10/14</i> , 19 <i>82</i> , to <i>1/23</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>1/22</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.    |  |   |   |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Joseph R. Liberto</i>   |  |   |   |   | DEGREE<br><i>MD</i>  |  |  | 22c. DATE SIGNED<br><i>1/24/83</i>                |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Joseph R. Liberto, M.D.   |  |   |   |   | 23b. ADDRESS<br>3508 Bank Street Baltimore, Md.                            |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   | 23b. DATE<br>Jan 26, 83   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Sacred Heart of Jesus Baltimore, Md. |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE           |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><i>Dign Funerals, Inc.</i>  |  |   | ADDRESS<br>7110 Belair Road Baltimore, Md.                          |   | 25a. DATE REC'D BY REGISTRAR<br>JAN 26 1983                                |  |  |   |  |  |  |



*Handwritten text, possibly a signature or date.*



*Handwritten text at the bottom left, possibly a date or reference number.*

*Handwritten text at the bottom right, possibly a signature or reference number.*



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 83 01351  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH, MONTH DAY YEAR  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>JOSEPH P. SCHRUEFER  |  |  |  | 2b. DATE OF DEATH, MONTH DAY YEAR<br>01/12/1983  |  |   |  |
| 3. SEX<br>Male   |  |  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 6, 1894  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>88 YRS.   |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  | IF UNDER 24 HRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |  |  | 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |   |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>North Charles General Hospital   |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Executive   |  |   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>Construction  |  |  |  | 13a. STREET ADDRESS<br>4309 Buchanan Dr. 21211   |  |   |  |
| 13b. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  | 13c. STREET ADDRESS<br>4309 Buchanan Dr. 21211   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Joseph Schruefer  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Catherine Kirchner   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes   |  |  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>WW I   |  |   |  |
| 17. INFORMANT ADDRESS<br>Mrs. Charlette Jeunette, Same   |  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE - 4292<br>DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC CARDIO -<br>DUE TO, OR AS A CONSEQUENCE OF (c) VASCULAR DISEASE<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from 01/03/1983 to 01/12/1983, that (we) last saw the deceased alive on 01/12/1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>J. R. Ansari MD  |  |  |  | 22c. DATE SIGNED<br>01/12/1983   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ANSARI MD   |  |  |  | 22e. ADDRESS<br>NORTH CHARLES GEN HOSP. ETL.<br>BALTIMORE, MD 21218  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  |  | 23b. DATE<br>1/15/83   |  |   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley   |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Balto. County, MD   |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., MD 21212  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 13 1983   |  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br>John J. Connel   |  |  |  |  |  |   |  |

BP



Joseph  
Schuster  
Commissioner  
State of New York  
Albany  
New York  
Jan 1 1888  
Hon. J. B. Condit  
New York

Jan 1 1888  
Hon. J. B. Condit  
New York

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8301352<br>REG. NO.  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |  |  | 2b. HOUR                                     |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Louise H. Schuler</b>   |  |  |  | Jan. 12 1983   |  |  |  | 11:30 A.M.                                   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. IF UNDER 1 YEAR MONTHS DAYS               |  |
| Female   |  | White  |  | Oct. 22 1903   |  | 79 YRS   |  |  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |
| Md.  |  | U.S.A.   |  |  |  | Baltimore City MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| Baltimore  |  | 4509 Springwood Ave.   |  |  |  | Store Owner  |  | Rental & Giftware                            |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS                          |  |
| Md.  |  | -  |  | Baltimore  |  |  |  | 3212 McElderry St. 21205                     |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |  |  |
| Joseph Schuler   |  |  |  | Katherine Oeschler   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS  |  |  |  |
| no   |  | 218-32-3767  |  | Catherine Thalheimer   |  | 4100 N. Charles St. (niece)  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) <u>Abdominal Carcinomatosis</u>  |  |  |  |  |  |  |  | 3 months                                     |  |
| 1560 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of the Gall Bladder</u>   |  |  |  |  |  |  |  | 4-6 months                                   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastatic</u>   |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Pernicious Anemia</u>  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                               |  |  |  |
| 10/28/82   |  | Abdominal tumor  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                     |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |  |  |
|  |  | P.M. N.A. 19   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/28</u> , 19 <u>82</u> , to <u>12</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>1/4</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  | DEGREE   |  |  |  | 22c. DATE SIGNED                             |  |
| <u>A. Pidlaoan</u>   |  |  |  | MD   |  |  |  | 1/13/83                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |  |  |  |  |
| Dr. Arturo Pidlaoan  |  |  |  | 7811 Wise Ave.   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |
| Burial   |  | 1/15/83  |  | Sacred Heart Jesus   |  | Balto. Md.   |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
| Schimunek Funeral Home, Inc.<br>3331 Brehms Lane, Balto. Md. 21213   |  |  |  | JAN 18 1983  |  | <u>John J. Canfield</u>  |  |  |  |

BP.



JAN 18 1955

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, no injury, or other traumatic event, the medical examiner will be notified and a post-mortem will be required.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |  |   |   |  |
|--|---|--|---|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Vernon Edward Schweitzer</b>   |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-20-83</b>   |   | 2b. HOUR<br><b>11:45</b> AM  |
| 3 SEX<br><b>Male</b>   | 4 RACE<br><b>White</b>  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 12, 1905</b>   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Deaton Med Center</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>Elect. Maint. Revere</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Copper &amp; Brass</b>   |
| 13a. STATE<br><b>Maryland</b>  | 13b. COUNTY<br><b>---</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>1739 S. Charles St. Balto. Md. 21230</b>        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert Lee Schweitzer</b>   |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Elizabeth Turner</b>                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>218-10-3894</b>   | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Martha Schweitzer, Same as above</b>                        |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>3109</b> IMMEDIATE CAUSE (a) <b>Cardio Pulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic Chronic Brain Syndrome</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>9 months</b>  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)<br><b>Decubitus Ulcers</b>   |   |  |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 19c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART 1 OR PART 2)     |  |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                         |  |
| 22. I certify that (i) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (ii) (we) lost saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (ii) (we) (did) (did not) view the body after death.   |   |  |   |   |  |
| 22a. SIGNATURE<br><b>Robert Barthel</b>  |   | DEGREE<br><b>MD</b>  |   | 22b. DATE SIGNED<br><b>1/21/83</b>  |  |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)  |   | 22d. ADDRESS   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>Jan. 25, 1983</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>McGully Funeral Home, 130 E. Fort Ave. Balto. Md.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>1-27-83</b>  |   | 25b. REGISTRAR'S SIGNATURE  |  |



*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-6868.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 3 0 1 3 5 4   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>JOHN B. SCRIBE   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>1-17-83   |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>W. Cauc.   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 14 30  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>52 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PENNSYLVANIA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIVERSITY OF MARYLAND |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>ENGINEER  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>NAVY DEPT.  |  |
| 13a. STATE<br>MD.   |  | 13b. COUNTY<br>P.G.   |  | 13c. CITY OR TOWN<br>BOWIE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOHN SCRIBE   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Orehousky   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>yes   |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>207-24-4202   |  | 16c. ADDRESS<br>Beverly Scribe, 12202 Millstream Dr.,<br>Bowie, Md.   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>6869 IMMEDIATE CAUSE (a) SEPSIS WITH MULTIPLE ORGAN FAILURE  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>80 DAYS   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) MULTIPLE ABDOMINAL SEPSIS   |  |   |  | 60 DAYS   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) ABDOMINAL WOUND DISRUPTION  |  |   |  | 60 DAYS   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>11/19/82<br>11/29/82  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>LEAKAGE OF ESOPHAGOGASTROJUGAL ANAST.<br>MULTIPLE ENTEROCUTANEOUS FISTULAE      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (a) this hospital attended the deceased from 11/15/82, 19 83, to 1/17, 19 83, that (b) (we) lost saw the deceased alive on 1/17, 19 83, and that is (my) (our) opinion death occurred on the date and hour and from the causes stated above (c) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>GW Arnaud MD  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>1/17/83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GW ARNAUD  |  |   |  | 22e. ADDRESS<br>UNIVERSITY HOSPITAL<br>22 S. GREENE ST. BALTO 21201   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>Jan 21, 1983   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gilmore Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Austin, Penna.   |  |
| 24. FUNERAL DIRECTOR<br>NAME Beall Funeral Home<br>16000 Annapolis Rd., Bowie, Md.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 24 1983  |  |  |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Lohr  |  |  |  |





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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 3 5 5

REG. NO.

FOR  
STATE  
REGISTRAR

|   |  |   |  |   |                                      |   |  |
|---|--|---|--|---|--------------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CARRIE SCROGGINS</b> |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-9-83</b> |   | 2b. HOUR<br><b>3<sup>30</sup> PM</b> |   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>BLACK</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 1 03</b>   |                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>VA</b>                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>  |                                      | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Howard Scroggins</b>                   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mamie Wilson</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |                                      | 16b. SOCIAL SECURITY NO.<br><b>213038547</b>  |  |
| 17. INFORMANT<br>ADDRESS<br><b>Samuel Crutchfield 2801 W. North</b>                 |  |   |  |   |                                      |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

4241

IMMEDIATE CAUSE (a) **CARDIORESPIRATORY Collapse**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.(b) **CONGESTIVE HEART FAILURE**

DUE TO, OR AS A CONSEQUENCE OF

(c) **AORTIC STENOSIS**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

N/A

MEDICAL CERTIFICATION

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION<br><b>N/A</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>N/A</b>         |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-31-</b> 19 <b>82</b> to <b>1-9-</b> 19 <b>83</b> , that (I) (we) last<br>saw the deceased alive on <b>1-9-</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Thomas Leslie Palko</b>   |  |  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>1-9-83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Thomas Leslie Palko</b>  |  |  |  | 22e. ADDRESS   |  |   |  |

|  |  |                             |  |  |  |  |  |
|--|--|-----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                      |  | 23b. DATE<br><b>1/14/83</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Anne Arundel Co. MD</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 11 1983</b>          |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                      |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.



*[Faint, illegible handwritten text covering the page]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH-16 50M (1/81)  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |   |  |  |  |  |
|---|--|--|--|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  | 8 3 0 1 3 5 6   |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  |  | 2a. DATE OF DEATH   |  |  |  |  |
| FIRST MIDDLE LAST<br>JOSEPH RICHARD SEMONE  |  |  |  |  | MONTH DAY YEAR<br>01 12 83  |  |  |  |  |
| 3. SEX<br>Male  |  |  |  |  | 4. RACE<br>White  |  |  |  |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 22 27  |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>55 YRS.  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md   |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  |  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balt City MD.   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Balto  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore Gen Hospital                   |  |  |  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Disabled Radio  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Dispatcher   |  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md  |  |  |  |  | 13b. COUNTY<br>Balto  |  |  |  |  |
| 13c. CITY OR TOWN<br>Balto  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |
| 13e. STREET ADDRESS<br>137 E. Brickhead St. Balt Md   |  |  |  |  | 13f. ZIP CODE<br>21230  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Semone  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Viola Hyde   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>213-26-2346   |  |  |  |  |
| 17. INFORMANT<br>chart, Mrs. Peggy Ann Semone, Same as # 13   |  |  |  |  | ADDRESS   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) cardio respiratory arrest<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) pulmonary edema<br>4 days<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) myocardial infarction<br>4 days<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br>Chronic renal failure |  |  |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |  |
| 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> |  |  |  |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/8 to 1/12, 1983, that (I) (we) lost saw the deceased alive on 1/12, 1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.   |  |  |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br>Anna Barnett  |  |  |  |  | 22c. DATE SIGNED<br>1-12-83   |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Anna Barnett   |  |  |  |  | 22e. ADDRESS<br>3001 S. Hanover St. Balto, Md 21230   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  |  |  | 23b. DATE<br>Jan. 15, 1983  |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery   |  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland   |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>McCutty Funeral Home, 130 E. Fort Ave. Balto, Md. 21230   |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 13 1983  |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br>John J. Givish  |  |  |  |  |   |  |  |  |  |

BP



17-2-1950

Received of Mr. J. H. Smith  
the sum of £10.00

for the purchase of 10 shares

at the rate of £1.00 per share

being the amount of the

subscription for 10 shares

of the company

at the rate of £1.00 per share

being the amount of the

subscription for 10 shares

of the company

at the rate of £1.00 per share

being the amount of the

subscription for 10 shares

of the company

at the rate of £1.00 per share

being the amount of the

subscription for 10 shares

of the company

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 affords any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |  | 8301357  |  |
|---|--|---|--|---|--|--|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |   |  |  |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ANTHONY SERIO</b>  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 21, 1983</b>   |  | 2b. HOUR<br>MIN<br><b>3:30</b>  |  | A  |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11-1-1902</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>80</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>80</b>   |  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>80</b>          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CHURCH HOSPITAL</b> |  |   |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MAINTENANCE MAN</b>                                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CAN. CO.</b> |  |
| 13a. STATE<br><b>MD.</b>  |  | 13b. COUNTY<br><b>BALTO.</b>  |  | 13c. CITY OR TOWN<br><b>BALTO.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>3733 WHITEPINE RD.</b>  |  | 21220  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ANTONIO SERIO</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218-01-3837</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Walma A. Serio - 3733 Whitepine Rd.</b>   |  |  |  | 21220   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4120 IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST</b>  |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH      |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>ACUTE PULMONARY ARREST EDEMA</b><br>(c) <b>CARDIAC ARRYTHMIA ATRIAL FIBRILLATION WITH VENSTRICULAR RESPONSE AND RUNS OF VENTRICULAR TACHYCARDIA</b>  |  |   |  |   |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS (Check one or more boxes if reported VENTRICULAR BASE TACHYCARDIA GIVEN IN PART 1 (a)<br><b>OLD MYOCARDIA INFARCTION, DIABETES MELLITUS</b>  |  |   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |  |  |
| 22a. I certify that (I (this hospital) attended the deceased from <b>JANUARY 18, 1983</b> to <b>JANUARY 21, 1983</b> that (I (we) lost saw the deceased alive on <b>January 21, 1983</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>F. Kawaja</b>  |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/21/83.</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>TINA KAWAJA</b>   |  |   |  |   |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION<br/>100 N. BROADWAY BALTIMORE, MARYLAND 21231</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>1-24-83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARDENS OF FAITH</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b>  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John J. Grier - 2334 Jefferson St.</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 24 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Grier</b>  |  |  |  |

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |   |  |  |   |
|---|---|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>James E. Sexmone</b>                       |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>1 18 1983</b>                               |  | 2b. HOUR<br><b>11:45 A</b>  |
| 3. SEX<br><b>Black</b>  | 4. RACE<br><b>Male</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 14 1910</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.                                  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                 |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                 |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University of Maryland Hosp</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Janitor</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><b>Maryland</b>   |   |   | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Saymone</b>                    |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Flora Elliott</b>              |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |   | 16b. SOCIAL SECURITY NO.<br><b>212 18 8907</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Nettie Seymore 49 40 Denmore Avenue</b> |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Hypertension**

**2394**  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Probable septicemia**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Bladder Tumor**

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

**Chronic renal Failure, Congestive heart Failure, heart disease**

|   |  |  |  |  |   |
|---|--|--|--|--|---|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>January 17, 19 83</b> , to <b>January 18, 19 83</b> , that (I) (we) lost<br>saw the deceased live on <b>January 18, 19 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (We) did (did not) view the body after death. |  |  |  |  |   |
| 22b. SIGNATURE<br><b>Charles E. Sheehan</b>   |  | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>1/18/83</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Charles E. Sheehan M.D.</b>   |  | 22e. ADDRESS<br><b>University of Maryland</b>                          |  |  |   |

|   |                             |   |  |
|---|-----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                             | 23b. DATE<br><b>1/22/83</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus Md.</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H Inc, 1101 E. North Avenue</b> |                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 20 1983</b>           | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>              |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |   |   |   | 83 01359   |  |
|--|---|---|---|--|--|
| 1. FOR STATE REGISTRAR   |   |   |   | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ROBERT LEO SHANAHAN   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>1-30-83                                     |  | 2b. HOUR<br>8:30 AM  |
| 3. SEX<br>m  | 4. RACE<br>w  | 5. DATE OF BIRTH MONTH DAY YEAR<br>11-12-24   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>58 YRS.                                      |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN.          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>35 MARYLAND   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                      |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL E.R. |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SHIPPING CLERK | 12b. KIND OF BUSINESS OR INDUSTRY<br>LITHOGRAPHING                     |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MARYLAND   |   |   | 13b. COUNTY   | 13c. CITY OR TOWN<br>BALTIMORE   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>FRANK MARTIN SHANAHAN   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>MARGARET MARIE REIS               |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>YES   |   |   | 16b. SOCIAL SECURITY NO.<br>218-18-5948   | 17. INFORMANT ADDRESS<br>CHARLES V. SHANAHAN 339 OAKLEE VILLAGE 21229  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>1539 IMMEDIATE CAUSE (a) Cardio-Pulmonary arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) Long Standing Ca Colon with spread<br>DUE TO, OR AS A CONSEQUENCE OF (c) Ca of Colon<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)          |   |  |  |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   |  |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |   |  |  |
| 22b. SIGNATURE<br>M.D.   |   | DEGREE<br>M.D.  |   | 22c. DATE SIGNED<br>1/30/83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>M. SANCHEZ  |   | 22e. ADDRESS<br>ST. AGNES ER. BALTIMORE 21229   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |   | 23b. DATE<br>02-01-83   | 23c. NAME OF CEMETERY OR CREMATORY<br>NEW CATHEDRAL                             |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTIMORE CITY MARYLAND |
| 24. FUNERAL DIRECTOR NAME<br>HUBBARD FUNERAL HOME, INC.  |   | ADDRESS<br>4107 WILKENS AVE.  |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 31 1983                           | 25b. REGISTRAR'S SIGNATURE<br>Joan J. Conner                       |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PH-3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                      |   |   |   |  |  |  |   | REG. NO. 3 0 1 3 6 0  |  |
|--|--|----------------------|---|---|---|--|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SAMUEL SHAROKY</b>  |  |                      |   |   |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1 3 19 83</b>  |  | 2b. HOUR <b>7:55</b>  |   |  |
| 3. SEX <b>MALE</b>   |  | 4. RACE <b>WHITE</b> |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>MAR. 6, 1923</b>            |   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS.   |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>1 3 19 83</b>  |   | 2d. HOUR <b>7:55</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>  |  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.      |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran Hospital</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>REPRESENTATIVE</b>          |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>UNION</b>                      |   |  |
| 13a. STATE <b>MARYLAND</b>   |  |                      | 13b. COUNTY <b>BALTIMORE</b>  |   | 13c. CITY OR TOWN <b>RANDALLSTOWN</b>                               |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>3730 OFFUTT RD. #21133</b>                   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>MAX SHAROKY</b>  |  |                      |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>SOPHIE UNKNOWN</b> |  |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>NO</b>  |  |                      |   |   | 16b. SOCIAL SECURITY NO. <b>215-14-9021</b>                         |  | 17. INFORMANT <b>MRS. JOSEPHINE SHAROKY</b><br><b>3730 OFFUTT RD. RANDALLSTOWN, MD 21133</b> |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                      |   |   |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |                      |   |   |   |  |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  |                      |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                 |   |  |  |  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b> |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                      |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)       |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |   |   |   |  |  |  |   |   |  |
| ACTUAL SIGNATURE    |  |                      |   | TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER                 |   |  |  | DATE SIGNED <b>1-4-83</b>  |   |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>  |  |                      |   | ADDRESS <b>111 Penn St., Balto., Md. 21201</b>                    |   |  |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  |                      |   | 23b. DATE <b>JAN. 5, 1983</b>                                     |   | 23c. NAME OF CEMETERY OR CREMATORY <b>WORKMEN CIRCLE</b>   |  |  | 23d. LOCATION<br>CITY <b>BALTIMORE</b> COUNTY <b>MARYLAND</b> STATE |   |  |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b><br>NAME ADDRESS <b>60011 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |                      |   |   |   | 25a. DATE REC'D. BY REGISTRAR <b>JAN 12 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE  |   |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |  |   |  |
|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Alice B. Shaw</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 4, 1983</b>          |   | 2b. HOUR P<br><b>4:52 M</b>                  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Black</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 24 26</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)       |   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| 13a. STATE<br><b>Maryland</b>  |   |   | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Samuel Little</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Latha Winfield</b> |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>  |  | 17. INFORMANT ADDRESS<br><b>Carolyn Webb 915 Kevin Road</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1509</b> IMMEDIATE CAUSE (a) <b>Aspiration</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Tracheal- Esophagial Fistula</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Squamous Cell Carcinoma of Esophagus</b> |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>December 27, 1982</b> to <b>January 4, 1983</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>January 4, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.             |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Richard A. Lane</b> MD  |   |   |  | 22c. DATE SIGNED<br><b>1/5/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Richard A. Lane, M.D.</b>  |   |   |  | 22e. ADDRESS<br><b>Co/ Maryland General Hospital</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>   |   | 23b. DATE<br><b>1/10/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b>  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. MD.</b>   |   |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H Inc. 1101 E. North Ave</b>   |   |   |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>JAN 6 1983</b> <b>Joan J. Connel</b> |  |



January 4, 1953

January

1953

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Baltimore City

Mar. 1953 - General Hospital

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1953 - General Hospital

1953 - General Hospital

January

1953

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1953 - General Hospital

1953 - General Hospital

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 3 6 2

FOR  
1. STATE  
REGISTRAR

REG. NO.

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Arbery SHAW</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01/08/83</b>           |  | 2b. HOUR<br><b>325A</b> <sup>M</sup>   |
| 3 SEX<br><b>Male</b>  | 4 RACE<br><b>Black</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 8 08</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b><br>YRS                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Fla.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City, Baltimore</b> MD.             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>   |  |   | 13b. COUNTY<br><b>Baltimore</b>                                  | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Willie Shaw</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mamie</b>    |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>578-12-7566</b>  |  | 17. INFORMANT ADDRESS<br><b>Mamie Shaw 3406 Calloway Avenue</b>                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>4787</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Acute Laryngo spasm</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/8</b> , 19 <b>83</b> , to <b>1/8</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1/8</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                           |  |   |  |  |  |
| 21g. SIGNATURE<br><b>Michael Koger MD</b>   |  |   |  | 22c. DATE SIGNED<br><b>1/8/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Michael Koger, MD</b>   |  |   |  | 22e. ADDRESS<br><b>2600 Liberty Heights Ave. 21215</b>                         |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/13/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cemetery</b>               |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b>   |  | 25a. DATE RECEIVED BY REGISTRAR<br><b>JAN 10 1983</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>   |  | ADDRESS<br><b>1101 E. North Ave.</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                            |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the Store Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED  
JAN 10 1917  
U.S. DEPT. OF AGRICULTURE

Handwritten notes and signatures, including "JAN 10 1917" and "JAN 10 1917".

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

8 3 0 1 3 6 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |  |
|--|--|--|---|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Elizabeth A Shearer</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 8 83</b>   |   | 2b. HOUR<br><b>1145 AM</b>  |  |
| 3 SEX<br><b>Female</b>   | 4 RACE<br><b>white</b>   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>08 28 1897</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore city</b> MD.                                |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore General Hospital</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>housewife</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>home</b>             |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>MD</b>   |  | 13b. COUNTY<br><b>A.A.</b>   | 13c. CITY OR TOWN<br><b>Brooklyn</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>917 12<sup>th</sup> St (21225)</b> |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Daniel Redell</b>  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary James</b>  |   |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b SOCIAL SECURITY NO.<br><b>1213-74-8393</b>   |   | 17 INFORMANT<br><b>Lawrence Shearer Jr. (same as 13e)</b>                                       |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY:<br><b>3489 IMMEDIATE CAUSE (a) cardiac arrest</b>  |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 MIN</b> |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Diffuse cerebral damage</b>   |  |  |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |   |   |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Carcinoma of colon, Gastric ulcers, Renal calculi</b>   |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OF PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 7, 1983</b> to <b>JAN 8, 1983</b> , that (I) (we) last saw the deceased alive on <b>JAN 8, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |
| 22b. SIGNATURE<br><b>Peter H Cooke</b>   |  | DEGREE<br><b>MD</b>  |   | 22c. DATE SIGNED<br><b>1/8/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PETER H COOKE</b>  |  | 22e. ADDRESS<br><b>3001 S HANOVER ST Bc (to MD)</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>   |  | 23b. DATE<br><b>1/12/83</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Memorial</b>                                |  |
| 23d. LOCATION<br><b>Glen Burnie</b>  |  | COUNTY<br><b>Md.</b>   |   |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>George J. Gonce</b>  |  | 24b. ADDRESS<br><b>F.H. 4001 Ritchie Hgwy.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 10 1983</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John J. Gonce</b>   |  |  |   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORT-NOT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified above.)

SECRET

(S)

SECRET

NOTICE

SECRET

SECRET

SECRET

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP \_\_\_\_\_

DHMH - 16 50M 1/81  
(VRA 15, 4)

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medic

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   |   |  | 8301364   |
|---|---|---|--|---|
| FOR<br>STATE<br>REGISTRAR   |   | REG. NO.  |  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   | 2a. DATE OF DEATH   |  | 2b. HOUR  |
| Marguerite E. Shearer   |   | January 23, 1983  |  |   |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |
| Female  | White   | March 21, 1903  |  | 79 YRS.   |
| 7. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |
| Pennsylvania  | U.S.A.  |   |  | Baltimore City  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   | 12b. KIND OF BUSINESS OR INDUSTRY                                   |
| Baltimore   | 1302 W. Old Coldspring Lane   |   | Housewife  |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   | 13b. COUNTY   | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  |
| Maryland  |   |   | Baltimore  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME   |   | 15. MOTHER'S MAIDEN NAME  |  |   |
| John W. Storm   |   | Lillie M. Althoff   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   | 16b. SOCIAL SECURITY NO.  | 17. INFORMANT ADDRESS  |   |
| No  |   | 213 20 1267   | Lloyd W. Shearer 510 SweetGum Rd. Riva, Md.  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                     |
| 4292 IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>  |   |   |  | 17 minutes  |
| DUE TO, OR AS A CONSEQUENCE OF  |   |   |  |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |   |   |  |   |
| DUE TO, OR AS A CONSEQUENCE OF  |   |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |   |   |  |   |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |
|   |   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |
|   |   |   |  |   |
| 21d. INJURY OCCURRED  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   |   |  |   |
| 22a. I certify that (1) this hospital attended the deceased from 11:00 A.M. 19 82 to 1:00 P.M. 19 83, that (2) we lost sight of the deceased about 12:15 P.M. 19 83 and that (3) in my (our) opinion death occurred on the date and hour and from the causes stated |   |   |  |   |
| 22b. SIGNATURE  |   | DEGREE  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED  |
| <u>Richard J. Diamond</u>   |   | MD  |  | 1/24/83   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |   | 22e. ADDRESS  |  |   |
| Dr. Richard Diamond   |   | 3547 Chestnut Avenue, Baltimore, Md.  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |   |
| Burial  | 1/17/83   | St. Joseph Cemetery   | Hanover, York Co., Penna   |   |
| 24. FUNERAL DIRECTOR  |   | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |
| Burgee Funeral Home, 3631 Falls Rd. Balto. Md.  |   | JAN 24 1983   |  | <u>John J. Shearer</u>  |

January 23, 1903

Mr. J. H. ...

March 21, 1903

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |   |   |  |  |  |  |
|---|--|---|---|---|---|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |   |   | REG. NO.  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>LEROY NMN SHERMAN  |  |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>1 11 83             |  |  |  |  |
| 3. SEX<br>male  |  | 4. RACE<br>Black  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>12 12 23   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS.   |  | 2b. HOUR<br>11:05PM  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Florida  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VAMC, BALTIMORE, MARYLAND 21218 |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN<br>Baltimore  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>3149 Elmora Ave. 21213  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>N/A  |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>N/A   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes  |  |   |   | 16b. SOCIAL SECURITY NO.<br>260 20 7554   |   | 17. INFORMANT ADDRESS<br>Evelyn Sherman 3149 Elmora Avenue   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>sq. cell cancer of lung and</u><br><u>1629</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>2nd primary of tonsil</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |   |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that <u>XX</u> (this hospital) attended the deceased from <u>January 11, 1983</u> to <u>January 11, 1983</u> , that <u>(X)</u> (we) lost saw the deceased alive on <u>January 11, 1983</u> , and that in <u>(X)</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>(X)</u> (we) (did not) view the body after death.   |  |   |   |   |   |  |  |  |  |
| 22b. SIGNATURE <u>Carla A. Alexander, MD</u> DEGREE <u>MD</u>   |  |   |   |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>1/12/83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Carla A. Alexander</u> (PK)   |  |   |   |   |   | 22e. ADDRESS<br>VAMC, Baltimore, Maryland 21218  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>CREMATION  |  |   | 23b. DATE<br>1/13/83  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Mem. Pk. |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Md. |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Wm. C. March F/H Inc. 1101 E. North Ave  |  |   |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 13 1983   |  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Smith</u>   |  |

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Vertical handwritten text, possibly a date or list of items.



Handwritten text, possibly a signature or name, in cursive script.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please retain a copy of this certificate for the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>GLADYS Viola SHIFFLETT  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>1 11 83                                      |  | 2b. HOUR<br>12:45 PM   |
| 3. SEX<br>FEMALE   | 4. RACE<br>WHITE   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3/26/1917   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                       |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hosp. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Inspector    | 12b. KIND OF BUSINESS OR INDUSTRY<br>W. J. Dickey                                    |  |
| 13a. STATE<br>Maryland   |  |   | 13b. COUNTY<br>Baltimore   | 13c. CITY OR TOWN<br>Ellicott City   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Albert C. McKenzie   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Nettie May Eyler                |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>218 09 1371   | 17. INFORMANT<br>3746 Maryland Ave.<br>Jane Hinegardner Ellicott City, Md. 21043 |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Terminal cardiac</i><br><i>2500</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <i>marked coronary artery disease</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <i>poorly controlled Diabetes Mellitus</i>                |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><i>minutes</i><br><i>years</i><br><i>years</i>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (we) (this hospital) attended the deceased from <i>12/20/82</i> , 19____, to <i>1/11/83</i> , 19____, that (we) lost<br>saw the deceased alive on <i>1/11/83</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (b) (we) (did) (did not) view the body after death. |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Robert E. Cranley</i>   |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br><i>1/12/83</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert E. CRANLEY   |  | 22e. ADDRESS<br>ST PONES HOSP   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>1/14/83  | 23c. NAME OF CEMETERY OR CREMATORY<br>Good Shepherd Cem.                         |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Ellicott City, Howard, Maryland  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SLACK Funeral Home, Ellicott City, Md. 21043   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 17 1983                                     |  |  |
|  |  |   | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Carney</i>                              |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 3 6 7

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |  |   |   |   |
|---|---|--|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Wayne Edward Shifflett</b>   |   |  | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>27</b> YEAR <b>83</b>                                |   | 2b. HOUR <b>2:07</b> M <b>PM</b>                          |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH <b>5</b> DAY <b>9</b> YEAR <b>1958</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>24</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>            |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                     |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospital</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborer-Harrison Steel Co.</b> |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Edgemere</b>   |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>2404 Sparrows Pt. Rd. 21219</b> |
| 14. FATHER'S NAME<br>FIRST <b>Cecil</b> MIDDLE <b>McKinley</b> LAST <b>Shifflett</b>  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mary</b> MIDDLE <b>Elizabeth</b> LAST <b>Buyny</b>         |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>216-72-5121</b>   |   | 17. INFORMANT<br><b>Mary E. Shifflett</b> ADDRESS <b>2700 Yorkway Apt B Balto., MD. 21222</b>         |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>8909</b> IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Inhalation Injury</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Burns</b> |   |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |  |   |   |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                  |   |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/><br>OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   |   |   |
| 21b. TIME OF INJURY<br>HOUR <b>3</b> A.M. MONTH <b>1</b> DAY <b>22</b> YEAR <b>1983</b><br>P.M.   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>Pt's house caught on fire</b>   |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>2404 Sparrows Point 2404 Sparrows Point, Balto.</b>   |   |   |   |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Baltimore City Baltimore MD</b>   |   | 22a. I certify that (I) (this hospital) attended the deceased from <b>1/22/83</b> to <b>1/27/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |   |
| 22b. SIGNATURE<br><b>Joseph E. Osterlind</b>  |   | DEGREE<br><b>MD</b>  |   | 22c. DATE SIGNED<br><b>1/27/83</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Joseph E. Osterlind</b>   |   | 22e. ADDRESS<br><b>Baltimore City Hospital</b>   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>1/31/1983</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Moriah Cem.</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>White Hall Virginia</b>                              |   |
| 24. FUNERAL DIRECTOR<br>NAME <b>Duda-Ruck, Inc.</b> ADDRESS <b>7922 Wise Avenue Dundalk, MD. 21222</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 31 1983</b>  |   |   |   |

MEDICAL CERTIFICATION

Released on approval by **MD**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If from the time worked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



Handwritten text at the bottom left, possibly a signature or date: "JAN 18 1891".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  | REG. NO.   |           |  |                  |                                   |                                   |
|--|--|--|--|---|--|--|--|--|--|--|-----------|--|------------------|-----------------------------------|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>HAROLD  |  | MIDDLE<br>C.  |  | LAST<br>SHINDLE, SR.   |  | 2a. DATE OF DEATH  |  | MONTH<br>1                                       | DAY<br>22 | YEAR<br>83                                   | 2b. HOUR<br>9:25 | MIN.<br>A                         |                                   |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH  |  | MONTH<br>12  |  | DAY<br>4   |  | YEAR<br>1920                                     |           | 6. AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS.   |                  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS | IF UNDER 24 HRS.<br>HOURS<br>MIN. |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Pennsylvania   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |  |  |  |           |  |                  |                                   |                                   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE CITY  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>N. Charles General Hospital |  |   |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Millwright   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Beth. Steel |           |  |                  |                                   |                                   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Dundalk   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  | 13e. STREET ADDRESS<br>7302 School Avenue 21222  |           |  |                  |                                   |                                   |
| 14. FATHER'S NAME<br>FIRST<br>Bailey   |  |  |  | MIDDLE<br>M.  |  | LAST<br>Shindle  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>Phoebe  |  |  |           | MIDDLE<br>A.                                 |                  | LAST<br>Wilson                    |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  |  |  | 16b. SOCIAL SECURITY NO.<br>218-07-1346   |  | 17. INFORMANT<br>Ruth L. Shindle   |  |  |  | ADDRESS<br>7302 School Ave.<br>Balto., MD. 21222 |           |  |                  |                                   |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>5715 IMMEDIATE CAUSE (a) BLEEDING Esophageal Varices<br>DUE TO, OR AS A CONSEQUENCE OF (b) Cirrhosis of Liver<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) |  |  |  |   |  |  |  |  |  |  |           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                  |                                   |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |  |  |  |           |  |                  |                                   |                                   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |           |  |                  |                                   |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |  |           |  |                  |                                   |                                   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |           |  |                  |                                   |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/21 1983, to 1/22 1983, that (I) (we) last saw the deceased alive on 1/22 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                       |  |  |  |   |  |  |  |  |  |  |           |  |                  |                                   |                                   |
| 22b. SIGNATURE<br>Marcos B. Galicia, Jr. MD  |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>1/22/83  |  |  |           |  |                  |                                   |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MARCOB B. GALICIA, JR MD  |  |  |  |   |  | 22e. ADDRESS<br>North Charles Gen. Hospital  |  |  |  |  |           |  |                  |                                   |                                   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |  | 23b. DATE<br>1/26/83   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland   |  |  |  |  |           |  |                  |                                   |                                   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Duda-Ruck, Inc.<br>7922 Wise Avenue Dundalk, MD. 21222   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 24 1983   |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Conner   |  |  |           |  |                  |                                   |                                   |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
1. STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |   |  |   |  |  |
|--|--|---|--|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JEANNETTE M. SHIPLEY  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JAN 18 83                       |   |   | 2b. HOUR<br>1030 PM  |   |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>BLACK  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 2 1918  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS.   |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                          |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI HOSPITAL |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>-                |   |  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>-   |  |   |  |   |   |  |   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD   |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 13e. STREET ADDRESS<br>3037 W. Belvedere Ave   |  |   | 21215  |   |   |  |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Johnnie Hanson   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Goldie Jackson   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  |   | 16b. SOCIAL SECURITY NO.<br>213-70-0006                                |   | 17. INFORMANT<br>ADDRESS<br>William E. Shipley 3037 W. Belvedere Avenue       |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Adeno carcinoma of Lung<br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-17-83, to 1-18-83, that (II) (we) lost saw the deceased alive on 1-18-83, and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above (II) (we) (did) not view the body after death.  |  |   |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br>JEFFREY M. MOCC MD   |  |   |  |   |   | 22c. DATE SIGNED<br>1-18-83  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  |   |   | 22e. ADDRESS<br>SINAI HOSPITAL   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  |   | 23b. DATE<br>1/22/83   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mount Auburn Cem.                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.                                     |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H Inc. 1101 E. North Avenue   |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 20 1983   |   | 25b. REGISTRAR'S SIGNATURE<br>John J. Connel   |  |

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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 3.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE RECORDS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |              |  |   |   |   |  |   |   |  | REG. NO. 01370 |  |
|---|--------------|--|---|---|---|--|---|---|--|----------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>VERNON SHORTER   |              |  |   |   |   | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>1 23 1983   |   | 2b. HOUR<br>M<br>1:35   |  |                |  |
| 3. SEX<br>M   | 4. RACE<br>I | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 10 07 76   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>76 YRS.               | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.<br>HOURS MIN.  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>1 23 1983  |   | 2d. HOUR<br>a M   |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MT AIRY MD   |              | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD  |   |   |  |                |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |              | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1102 Druid Hill Ave. |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                |  |
| 13a. STATE<br>MD  |              | 13b. COUNTY<br>BALTO.  | 13c. CITY OR TOWN<br>BALTO.                                 | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET ADDRESS<br>1102 Druid Hill Ave. 21201                             |  |   |   |  |                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Robert Shorter  |              |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>IRENE      |   |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO |   |   |  |                |  |
| 16a. SOCIAL SECURITY NO.<br>217-18-1153   |              |  | 17. INFORMANT ADDRESS<br>Elsie Shorter 1102 Druid Hill Ave. |   |   |  |   |   |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |              |  |   |   |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |              |  |   |   |   |  |   |   |  |                |  |
| 19a. DATE OF OPERATION  |              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |   |   |  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  |   |   |  |                |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |   |  |                |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |              |  |   |   |   |  |   |   |  |                |  |
| ACTUAL SIGNATURE<br>Ann M. Dixon, M.D.  |              |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER          |   |   |  | DATE SIGNED<br>1-23-83                                  |   |  |                |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Ann M. Dixon, M.D.   |              |  | ADDRESS<br>111 Penn St., Balto., Md. 21201                  |   |   |  |   |   |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |              | 23b. DATE<br>12-1-83   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>ARBUTUS CEMETERY  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. MD |   |  |                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leroy Odgers  |              |  | ADDRESS<br>4400 J. Edgar Hoover Hwy.                        |   |   | 25. DATE REC'D. BY REGISTRAR<br>JAN 24 1983  |   |   |  |                |  |
| REGISTRAR'S SIGNATURE<br>John J. Casper   |              |  |   |   |   |  |   |   |  |                |  |

1. To determine the effect of temperature on the rate of reaction between hydrogen peroxide and potassium iodide.

2. To determine the effect of concentration on the rate of reaction between hydrogen peroxide and potassium iodide.

3. To determine the effect of catalyst on the rate of reaction between hydrogen peroxide and potassium iodide.

4. To determine the effect of surface area on the rate of reaction between hydrogen peroxide and potassium iodide.

5. To determine the effect of pH on the rate of reaction between hydrogen peroxide and potassium iodide.

6. To determine the effect of ionic strength on the rate of reaction between hydrogen peroxide and potassium iodide.

7. To determine the effect of solvent on the rate of reaction between hydrogen peroxide and potassium iodide.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 8301371   |  |   |  |  |  |
|---|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | 26. DATE OF DEATH MONTH DAY YEAR 01-10-83  |  |   |  | 26. HOUR 3:32AM  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRED ROLAND SHOWACRE   |  |   |  | 26. DATE OF DEATH MONTH DAY YEAR 01-10-83  |  |   |  | 26. HOUR 3:32AM  |  |
| 3. SEX Male   |  | 4. RACE White   |  | 5. DATE OF BIRTH MONTH DAY YEAR 1 7 16   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.                           |  |  |  |
| 10. CITY OR TOWN OF DEATH Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Eng.                |  | 12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel  |  |
| 13a. STATE Maryland   |  |   |  | 13b. COUNTY Baltimore  |  | 13c. CITY OR TOWN Arbutus   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Washington Showacre  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertude Von Nordic  |  |   |  | 13e. STREET ADDRESS 1239 Seven Oaks Road 21227   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-07-8558  |  | 17. INFORMANT Fred Showacre  |  | ADDRESS 413 M St N.E.   |  | 21061  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4140 <u>due to Atherosclerotic heart disease,</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Renal Failure, 2° CHF</u><br><u>Carcinoma Prostate, Diabetes Mellitus &amp;</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Respiratory failure.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/25, 1982, to 1-10, 1983, that (I) (we) lost the deceased alive on 01-03-83 3:32 AM 1/10 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE KAUSHALENDRA K. SINGH  |  |   |  | DEGREE   |  | 22c. DATE SIGNED 1/10/83  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KAUSHALENDRA K. SINGH   |  |   |  | 22e. ADDRESS ST AGNES HOSPITAL 900 CATON AVE. BALTIMORE, 21229   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  | 23b. DATE 1/13/83   |  | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery  |  | 23d. LOCATION Baltimore   |  | CITY OR TOWN COUNTY STATE Maryland   |  |
| 24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.  |  |   |  | ADDRESS 21229 4107 Wilkens Ave.  |  | 25a. DATE REC'D. BY REGISTRAR JAN 12 1983   |  | 25b. REGISTRAR'S SIGNATURE John J. Canine  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and kept in the hospital or retained by the hospital or attending physician.

DHMM - 16 50M 1/81  
(VRA 15, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

## MEDICAL CERTIFICATION

| FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 3 0 1 3 7 2   |  |  |  |
|---|--|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH  |  |  |  | 2b. HOUR  |  |  |  |
| Mary Ann Shuminski  |  |  |  | Jan 29 83  |  |  |  | 0940 A.M.   |  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. IF UNDER 1 YEAR  |  | 7. IF UNDER 24 HRS.  |  |
| Female  |  | White  |  | 1 15 97  |  | 86 YRS.  |  | MONTHS DAYS   |  | HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |  |  |
| Pennsylvania  |  | U.S.A.   |  |  |  | Baltimore City MD.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |
| Baltimore   |  | South Baltimore General  |  |  |  | Housewife  |  | Home  |  |  |  |
| 13a. STATE  |  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  |  |  |
| Maryland  |  |  |  | 21230  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 14. FATHER'S NAME   |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  | 13e. STREET ADDRESS   |  |  |  |
| Patrick Walsh   |  |  |  | Roseann Rafferty   |  |  |  | 2512 Southdene Ave. 21230   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |   |  |  |  |
| No  |  |  |  | 166-14-2841  |  | Mary Lou Clements 2512 Southdene Ave 21230                                     |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| IMMEDIATE CAUSE (a) Cardiorespiratory arrest  |  |  |  |  |  |  |  |   |  |  |  |
| 4280 DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure.   |  |  |  |  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |  |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Probable duodenal angiodysplasia -  |  |  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |  |
|   |  |  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED  |  |  |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION  |  |   |  |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/10/82 to 1/29/83, that (I) (we) last saw the deceased alive on 1/29/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE  |  |  |  | DEGREE   |  |  |  | 22c. DATE SIGNED  |  |  |  |
| M. Nestor   |  |  |  | M.D.   |  |  |  | 1/29/83.  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |  |  |  |   |  |  |  |
| Nestor  |  |  |  | M.D. 3001 S. Hanover St.   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |  |  |
| Burial  |  |  |  | Feb. 1, 1983   |  | Saint Edwards Cem.   |  | Shimokin Northumberland PA  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |   |  |  |  |
| NAME William E. Johnson 8521 Loch Raven Blvd.   |  |  |  |  |  | ADDRESS  |  |   |  |  |  |
|   |  |  |  |  |  | JAN 31 1983 John J. Carver   |  |   |  |  |  |



Handwritten text, mostly illegible due to fading and bleed-through. Some words like "January" and "1933" are faintly visible.

Handwritten text, mostly illegible due to fading and bleed-through. Some words like "January" and "1933" are faintly visible.

Handwritten text, mostly illegible due to fading and bleed-through. Some words like "January" and "1933" are faintly visible.

Printed text at the bottom of the page, oriented upside down: "JAN 31 1933" and "Post Office".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be kept for 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked off, item 18 shows only injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| <div style="display: flex; justify-content: space-between;"> <div> <p>1 - FOR<br/>STATE<br/>REGISTRAR</p> </div> <div> <p>8 3 0 1 3 7 3</p> </div> </div>   |  |  |  |   |  |  |  |   |  |
| <div style="display: flex; justify-content: space-between;"> <div> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>REG. NO.</p> </div> </div>   |  |  |  |   |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Stanley Stephen Silkowski</b>  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1 21 83</b>   |  | 2b. HOUR<br><b>2 26 AM</b>   |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>May 4, 1911</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b>                             |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Scranton, Pa.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>            |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospital</b> |  |   |  | 12. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Manufacturing Technician</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Air Craft</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. CITY OR TOWN <b>Baltimore</b> 13c. STREET ADDRESS <b>Essex 21221</b>  |  |  |  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS <b>409 S. Taylor Ave.</b>                        |   |  |
| 14. FATHER'S NAME FIRST <b>Stanley</b> LAST <b>Silkowski</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST <b>Helen</b> LAST <b>Schultz</b>                              |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>205 07 4766</b>   |  | 17. INFORMANT<br><b>Mary Silkowski, Wife</b>  |  |  | ADDRESS<br><b>Same</b>   |   |  |
| <p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART 1. DEATH WAS CAUSED BY:</p> <p>4310 IMMEDIATE CAUSE (a) <b>Cardiac arrest</b></p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(b) <b>intracerebral hematoma</b></p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c)</p> <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)</p> |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| <p>22a. I certify that (I) (this hospital) attended the deceased from <b>1/24/83</b>, 19 <b>83</b>, to <b>1/21/83</b>, 19 <b>83</b>, that (I) (we) last saw the deceased alive on <b>1/21/83</b>, 19 <b>83</b>, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p>  |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Bruce Kinosian</b>   |  |  |  |   | DEGREE   |  |  | 22c. DATE SIGNED<br><b>1/21/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Bruce Kinosian</b>  |  |  |  |   | 22e. ADDRESS<br><b>Baltimore City 1730</b>   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/24/83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith Cemetery</b>  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Md.</b> |   |  |
| 24. FUNERAL DIRECTOR<br><b>Bruzdzinski Funeral Home PA 1407 Old Eastern Ave.</b>  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 25 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                  |   |  |

Stanley, William

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 3 7 4

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |  |   |  |  |  |
|---|--|--|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HELEN SILVERSTEIN</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JAN 22 83</b>                |   |  | 2b. HOUR<br><b>3:45 P.M.</b>   |   |  |  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>OCT. 28, 1900</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>STOCKBROKER</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>INVESTMENTS</b>  |  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |  | 13b. COUNTY<br><b>BALTO.</b>   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>DAVID LIPSIG</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ROSE UNKNOWN</b>   |   |  | 13e. STREET ADDRESS<br><b>7362 PARK HTS. AVE. #21208</b>   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>079-30-8051</b>                         |   | 17. INFORMANT<br><b>MRS. GERALDYNE LORAN</b>                                   |  |   |  | ADDRESS<br><b>7362 PARK HTS. AVE. BALTO., MD 21208</b>       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4100 IMMEDIATE CAUSE (a) Cardiac arrest</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>acute myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>2 weeks</b> |  |  |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>none</b>  |  |  |  |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 8</b> , 19 <b>83</b> , to <b>Jan 22</b> , 19 <b>83</b> , that (I) (we) lost<br>saw the deceased alive on <b>Jan 22</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.               |  |  |  |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Manuel Levin M.D.</b>  |  |  | DEGREE<br><b>M.D.</b>  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1/22/83</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MANUEL LEVIN M.D.</b>   |  |  | 22e. ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO MD 21215</b>            |   |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>  |  |  | 23b. DATE<br><b>JAN. 24, 1983</b>                                      |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE HEBREW</b>                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>REISTERSTOWN BALTO. MD</b>                     |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SOL LEVINSON &amp; BROS., INC.<br/>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 26 1983</b>                            |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canine</b>   |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove to the Registrar's Office, Room 101, 201 W. Preston St., Baltimore, Maryland 21201, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |   |   |   | 8 3 0 1 3 7 5   |  |
|---|---|---|---|---|--|
| 1. FOR STATE REGISTRAR  |   |   |   | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ETHEL SIMMONS</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 30 1983</b> |   | 2b. HOUR<br><b>09:40AM</b>                                       |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Black</b>                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 30 06</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76 YRS.</b>   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD</b>                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b>              |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |
| 13a. STATE<br><b>Maryland</b>   |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>                         | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Plummer Odum</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Katie Outlaw</b>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>213-01-8620</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Geneve Daye 2028 E. Lanvale Street</b>                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4275</b> IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Cerebral death</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>24 hr.</b> |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>0 min.</b> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>0</b>  |   |   |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |   |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>1/30 1983</b> to <b>1/30 1983</b> , that (1) (we) lost saw the deceased alive on <b>1/30 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) (did not) view the body after death.)                       |   |   |   |   |  |
| 22b. SIGNATURE<br><b>Marc Nelson</b>  |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>1/30/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Marc Nelson</b>   |   | 22e. ADDRESS<br><b>Johns Hopkins Hosp</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(1) <b>BURIAL</b>  |   | 23b. DATE<br><b>2/2/83</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus</b>     |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H Inc.</b>  |   | ADDRESS<br><b>1101 E. North Avenue</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 1 1983</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>   |   |   |   |   |  |



PLV

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate filed.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 3 7 6

REG. NO.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>SAMUEL SINGLETON   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1/27/83                         |  | 2b. HOUR<br>1:40 AM  |
| 3. SEX<br>M  | 4. RACE<br>B   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 15 06   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.                             |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>SC  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO CITY MD.                 |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MONTEBELLO HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br>MD   |  |   | 13b. COUNTY<br>Baltimore   | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>N/A  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>N/A                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>223-16-6791  | 17. INFORMANT<br>ADDRESS<br>Melvine Turlington 2816 W. Garrison Avenue |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>4960 IMMEDIATE CAUSE (a) Respiratory arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) COPD<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Cor Pulmonale   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/5, 19 82, to 1/27, 19 83, that (I) (we) last saw the deceased live on 1/27, 19 83, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |
| 22b. SIGNATURE<br>DEGREE<br>DAVID MATCHAR MD   |  |   |  | 22c. DATE SIGNED<br>1/27/83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DAVID MATCHAR   |  |   |  | 22e. ADDRESS<br>2201 Argonne Drive   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>1/31/83  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cemetery                             |  |
| 23d. LOCATION<br>CITY OR TOWN<br>Baltimore   |  | COUNTY<br>BALTO   |  | STATE<br>MD.   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H Inc. 1101 E. North Avenue   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 28 1983   |  |
| ADDRESS  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Gair   |  |

BP

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY



JAN 28 1903  
J. H. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the attending physician.

BP \_\_\_\_\_

DHMH - 16 50M (1/81)  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8301377

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Mary Jane Skelton</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1 18 83</b>  |   | 2b. HOUR<br><b>5:00 A</b>  |
| 3 SEX<br><b>FEMALE</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 17 97</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                                  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Teacher - Nursery School</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |   | 13b. CITY OR TOWN<br><b>Baltimore</b>   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13d. STREET ADDRESS<br><b>411-F Wheaton Pl. 21228</b>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thomas Skelton</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Katherine Doyle</b>                             |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>N/A</b>   | 17. INFORMANT ADDRESS<br><b>Margaret R. Pikey Same as #13</b>                                       |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br><b>4100 IMMEDIATE CAUSE (a) Cardiogenic Shock</b>  |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 hours</b>   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Acute Myocardial Infarction</b>   |  |   |   |   | <b>5 hours.</b>  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ASCD</b>  |  |   |   |   | <b>Years.</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |   |  |
| 19a. DATE OF OPERATION<br><b>None</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>None</b>   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/18/83</b> to <b>1/18/83</b> , that (I) (we) lost saw the deceased alive on <b>1/18/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |   |   |  |
| 22b. SIGNATURE<br><b>George J. Vellani</b>   |  |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>1/18/83</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>G. VELLANIKARAN</b>  |  |   | 22e. ADDRESS<br><b>St. Agnes Hospital, Baltimore MD-21228</b>                                       |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/22/83</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. John's Cem.</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Hyde, Baltimore, MD</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>MacNabb Funeral Home, Catonsville, MD</b>   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 19 1983</b>   |   |  |
|  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>   |   |  |

MEDICAL CERTIFICATION

29



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 1/2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by one of the following: 1. The attending physician, 2. The funeral director, 3. The coroner, or 4. The medical examiner.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 3 0 1 3 7 8   |  |
|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | CERTIFICATE OF DEATH  |  |
| 2. DECEASED NAME   |  |   |  | 2a. DATE OF DEATH   |  |
| FIRST MIDDLE LAST  |  |   |  | MONTH DAY YEAR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Mary E (Mamie) Slack   |  |   |  | 2a. DATE OF DEATH<br>January 10, 1983   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 2b. HOUR<br>7:30 P  |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 24, 1890  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>92 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3104 Glenmore Ave |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Baltimore  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Thomas   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary ?   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>220-48-7693   |  | 17. INFORMANT<br>Mrs Mabel Slipper  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a). 4292 ASCVD - CHF<br>(b). Stroke pneumonia left<br>(c).<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                               |  | 19. DATE OF OPERATION   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |  |
| 21c. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21d. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21e. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1, 1975, to Jan 10, 1983, that (I) (we) lost saw the deceased alive on Jan 8, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |
| 23a. SIGNATURE<br>Donald W Mintzer M.D.  |  | 23b. DEGREE   |  | 23c. DATE SIGNED<br>1/11/83   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J Ruck Inc. Baltimore, Maryland  |  | 24b. ADDRESS  |  | 25a. DATE REGD. BY REGISTRAR<br>JAN 12 1983   |  |
| 25b. REGISTRAR'S SIGNATURE   |  | 25c. ADDRESS<br>3009 Evergreen Ave Baltimore, Maryland  |  |   |  |
| 26a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 26b. DATE<br>1/13/83  |  | 26c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn  |  |
| 26d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland   |  | 26e. DATE REGD. BY REGISTRAR<br>JAN 12 1983   |  |   |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8-3 01379

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |                            |  |  |
|--|--|--|--|---|----------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>EUGENE R. SMEALLIE</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 02, 1983</b> |   | 2b. HOUR<br><b>04:54AM</b> |  |  |
| 1. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 26, 1916</b>  |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Architect</b>  |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Architecture</b>   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Towson</b>  |                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 13e. STREET ADDRESS<br><b>7306 Knollwood Rd. 21204</b>   |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Arthur W. Smeallie</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary A. Simkins</b>   |                            | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes WW II</b>       |  |
| 16b. SOCIAL SECURITY NO.<br><b>347-10-7198</b>   |  | 17. INFORMANT<br><b>Mrs. Mildred Smeallie,</b>   |  | ADDRESS<br><b>Same</b>  |                            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4100 IMMEDIATE CAUSE (a) Ventricular Tachycardia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>(b) myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>(c) Coronary Artery Disease</b>                        |  |  |  |   |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hour</b><br><b>2 weeks</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a   |  |  |  |   |                            |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                            |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 1, 1983</b> to <b>Jan 2, 1983</b> , that (I) (we) last saw the deceased alive on <b>Jan 2, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |                            |  |  |
| 22b. SIGNATURE<br><b>Phil Buescher</b>   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |                            | 22c. DATE SIGNED<br><b>12/3/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Phil Buescher</b>  |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSP</b>  |  |   |                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/5/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>   |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Co., MD</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b><br>ADDRESS<br><b>4905 York Road Balto., MD 21212</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 3 1983</b>  |                            | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial.

BP



Items #18a-22a Film G-577 57905-10 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |                               |  |                                |  |                                |  |                |  |          |  |
|---|--|--|--|---|--|---|--|-------------------------------|--|--------------------------------|--|--------------------------------|--|----------------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN<br>OF DEATH    |  | MONTH                          |  | DAY                            |  | YEAR           |  | 2b. HOUR |  |
| Bernard   |  | E.   |  | Smith   |  | Jr.   |  | 1                             |  | 24                             |  | 1983                           |  |                |  | M        |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)  |  | IF UNDER 1 YR.<br>MONTHS DAYS |  | IF UNDER 24 HRS.<br>HOURS MIN. |  | 2c. DATE<br>PRONOUNCED<br>DEAD |  | MONTH DAY YEAR |  | 2d. HOUR |  |
| male  |  | Black  |  | 8 4 53  |  | 29 YRS.   |  |                               |  |                                |  | 1 24 1983                      |  |                |  | P.M.     |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |                               |  |                                |  |                                |  |                |  |          |  |
| Maryland  |  | U.S.A.   |  |   |  | Baltimore City,   |  | MD.                           |  |                                |  |                                |  |                |  |          |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |  |                               |  |                                |  |                                |  |                |  |          |  |
| Baltimore   |  | Sinai Hospital   |  |   |  |   |  |                               |  |                                |  |                                |  |                |  |          |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS           |  |                                |  |                                |  |                |  |          |  |
| Maryland  |  |  |  | Baltimore   |  |   |  | 4603 Homer Avenue 21215       |  |                                |  |                                |  |                |  |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |  |   |  |   |  |                               |  |                                |  |                                |  |                |  |          |  |
| Bernard E. Smith, Sr.   |  | Sara Pugh  |  |   |  |   |  |                               |  |                                |  |                                |  |                |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |                               |  |                                |  |                                |  |                |  |          |  |
| No  |  | 216-58-1898  |  | Sara Gohleston  |  | 4603 Homer Avenue   |  |                               |  |                                |  |                                |  |                |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):)<br>PART I DEATH WAS CAUSED BY:<br>3049 IMMEDIATE CAUSE (a) Intravenous Narcotism.<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |   |  |   |  |                               |  |                                |  |                                |  |                |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |   |  |                               |  |                                |  |                                |  |                |  |          |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |                               |  |                                |  |                                |  |                |  |          |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |                               |  |                                |  |                                |  |                |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |                               |  |                                |  |                                |  |                |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |   |  |   |  |                               |  |                                |  |                                |  |                |  |          |  |
| ACTUAL SIGNATURE  |  | TITLE (SPECIFY)  |  | DATE SIGNED   |  |   |  |                               |  |                                |  |                                |  |                |  |          |  |
| Dennis F. Smyth, M.D.   |  | Assistant  |  | 1-25-83   |  |   |  |                               |  |                                |  |                                |  |                |  |          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |  | ADDRESS  |  |   |  |   |  |                               |  |                                |  |                                |  |                |  |          |  |
| Dennis F. Smyth, M.D.   |  | 111 Penn Street  |  |   |  |   |  |                               |  |                                |  |                                |  |                |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(13b. BURIAL)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN   |  | COUNTY                        |  | STATE                          |  |                                |  |                |  |          |  |
| BURIAL  |  | 1/29/83  |  | King Memorial Pk.   |  | Baltimore   |  | Co.                           |  | Md.                            |  |                                |  |                |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |                               |  |                                |  |                                |  |                |  |          |  |
| Wm. C. March F/H Inc.   |  | 1101 E. North Ave  |  | JAN 26 1983   |  | John J. Conner  |  |                               |  |                                |  |                                |  |                |  |          |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 01381

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |  |   |                                   |  |
|---|--|--|---|---|--|---|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | 2a. DATE OF DEATH   |   |  | 2b. HOUR  |                                   |  |
| EFFORD SMITH  |  |  | JANUARY 24, 1983  |   |  | 02:55AM   |                                   |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |   |  | 7. IF UNDER 1 YEAR  |                                   |  |
| male  | Black  | 9 9 17   | 65 YRS.   |   |  | MONTHS DAYS HOURS MIN.  |                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |   |  |   |                                   |  |
| Florida   | U.S.A.   |  | BALTIMORE CITY MD.  |   |  |   |                                   |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| BALTIMORE   | THE JOHNS HOPKINS HOSPITAL   |  |   |   |  |   |                                   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   |   |  |   |                                   |  |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS   |  |   |                                   |  |
| Maryland  |  | Baltimore  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 3419 Elmora Ave. 21213  |  |   |                                   |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME  |   |  |   |                                   |  |
| Wesley Smith  |  |  | G ertrude Day   |   |  |   |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.  |   |  | 17. INFORMANT ADDRESS   |                                   |  |
| No  |  |  | 265-18-0455   |   |  | Ella Mae Willis 3419 Elmora Ave.                                    |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |   |   |  |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| PART I. DEATH WAS CAUSED BY:  |  |  |   |   |  |   |                                   |  |
| 0389 IMMEDIATE CAUSE (a) CARDIAC ARREST   |  |  |   |   |  |   |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |   |  |   |                                   |  |
| (b) HYPOTENSION   |  |  |   |   |  |   |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |   |  |   |                                   |  |
| (c) SEPSIS  |  |  |   |   |  |   |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |   |   |  |   |                                   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY?   |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|   |  |  |   |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |                                   |  |
|   |  |  | HOUR A.M. MONTH DAY YEAR  |   |  |   |                                   |  |
|   |  |  | P.M. 19   |   |  |   |                                   |  |
| 21d. INJURY OCCURRED  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION  |   |                                   |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  |   |   | STREET CITY OR TOWN COUNTY STATE   |   |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/21, 1983, to 1/24, 1983, that (I) (we) last saw the deceased alive on 1/24, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |   |                                   |  |
| 22b. SIGNATURE  |  |  | DEGREE  |   |  | 22c. DATE SIGNED  |                                   |  |
| R. Michael Wyman  |  |  | MD  |   |  | 1/24/83   |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  | 22e. ADDRESS  |   |  |   |                                   |  |
| R. Michael Wyman  |  |  | JOHNS HOPKINS HOSPITAL  |   |  |   |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SIC)   |  |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION                     |  |
| BURIAL  |  |  | 1/28/83   |   | Baltimore Cemetery   |   | Baltimore Md.                     |  |
| 24. FUNERAL DIRECTOR  |  |  | 25a. DATE REC'D. BY REGISTRAR                                       |   |  | 25b. REGISTRAR'S SIGNATURE  |                                   |  |
| NAME Wm. C. March F/H Inc. 1101 E. North Avenue   |  |  | JAN 25 1983   |   |  | John J. Conner  |                                   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the death certificate file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 3 8 2

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |                              |  |                                     |
|--|--|--|--|---|------------------------------|--|-------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ELLA XX. RADER SMITH</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 12, 1983</b> |   | 2b. HOUR<br><b>9:43 P.M.</b> |  |                                     |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7/31/1936</b>  |                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>46</b><br>YRS. MONTHS DAYS HOURS MIN.  |                                     |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNSYLVANIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>  |                                     |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN BALTIMORE, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SALES SERV. SPEC.</b>  |                              | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>STATIONARY BRKR</b>  |                                     |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE COUNTY CITY OR TOWN<br><b>MARYLAND BALTIMORE DUNDALK</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>8109 BULLNECK RD. 21222</b>   |                              |  |                                     |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GEORGE RADER</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MYRTLE SPRINGER</b>  |  |   |                              |  |                                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>216.30.5258</b>   |  | 17. INFORMANT<br><b>DEBRA A. SMITH</b>  |                              |  | 17e. ADDRESS<br><b>SAME AS 13e.</b> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1830 IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost:<br>(b) <b>Ovarian Cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 1/2 yr.</b> |  |  |  |   |                              |  |                                     |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |   |                              |  |                                     |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                     |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                              |  |                                     |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                              |  |                                     |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/21</b> , 19 <b>81</b> , to <b>1/12</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>1/12</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |                              |  |                                     |
| 22b. SIGNATURE<br><b>R. J. Noto</b>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |                              | 22c. DATE SIGNED<br><b>1/12/83</b>   |                                     |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. J. Noto</b>   |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>  |  |   |                              |  |                                     |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>1/15/1983</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OAK LAWN CEMETERY</b>  |                              | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b>  |                                     |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 17 1983</b>   |                              | 25b. REGISTRAR'S SIGNATURE<br><b>John L. Smith</b>   |                                     |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP





CHIEF

208 COLT

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |   |  |   |  |   |   |  |               | REG. NO. 3 0 1 3 8 3  |  |
|--|--|---|--|---|--|---|---|--|---------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>GEORGE M. SMITH  |  |   |  |   |  |   | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>1-24-83 <sup>19</sup> |  | 2b. HOUR<br>M |   |  |
| 3. SEX<br>male   |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>12 18 35                           |  | 6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS.   |   | 7. IF UNDER 1 YR. MONTHS DAYS                              |               | 2c. DATE PRONOUNCED DEAD<br>1-24-83 <sup>19</sup> 9:45A                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD. |               |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>S.T.U. University Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY                          |               |   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS<br>1103 N. Whatcoat St                 |               | 21217   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>George A. Hill  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Marie Smith             |  |   |   |  |               |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  |   |  | 16b. SOCIAL SECURITY NO.<br>N/A                                       |  | 17. INFORMANT ADDRESS<br>Elsie M. Wright 224 N. Hilton St.  |   |  |               |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Multiple injuries with complications</u><br>8147<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |   |  |   |   |  |               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |   |  |   |  |   |   |  |               |   |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                     |  |   |   |  |               | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |   |  | 21b. TIME OF INJURY HOUR AM MONTH DAY YEAR<br>9:40AM 1-24-83          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br>pedestrian struck by an auto   |   |  |               |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>street |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br>200 blk. Dolphin St. Baltimore, Maryland  |   |  |               |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |   |  |   |  |   |   |  |               |   |  |
| ACTUAL SIGNATURE<br><i>Margarita A. Koroll</i>   |  |   |  | TITLE (SPECIFY)<br>Assistant MEDICAL EXAMINER                         |  |   |   | DATE SIGNED<br>1-26-83                                     |               |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Margarita A. Koroll, M.D.   |  |   |  | ADDRESS<br>111 Penn Street  |  |   |   |  |               |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>1/29/83  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mount Auburn Cem.               |  |   |   | 23d. LOCATION CITY OR TOWN<br>Baltimore                    |               | COUNTY STATE<br>Md.   |  |
| 24. FUNERAL DIRECTOR NAME<br>Wm. C. March F/H Inc.   |  |   |  |   |  | ADDRESS<br>1101 E. North Ave  |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 26 1983               |               | 25b. REGISTRAR'S SIGNATURE<br><i>Joan J. Connel</i>                                 |  |

BP

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]  
DATE: [illegible]  
[The following text is extremely faint and largely illegible, appearing to be a memorandum or report. It contains several paragraphs of text, some of which are indented. There are also some handwritten marks and numbers scattered throughout the page.]

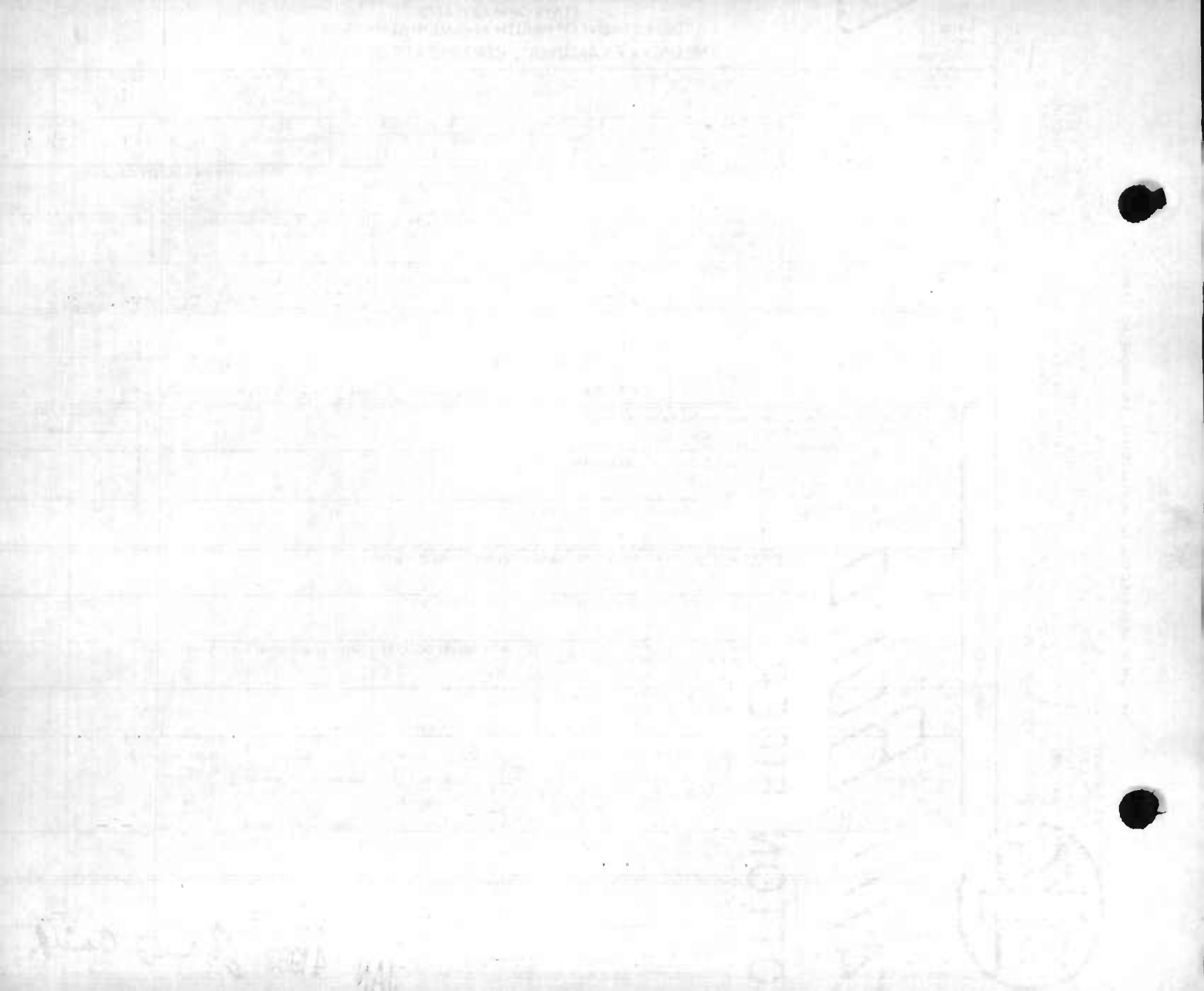
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RECEIVED BY [illegible] 11-1-62

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 7 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR STATE REGISTRAR   |  |                  |  |  |  |   |  |   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |                                   |  |   |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |                     |  |  |  |  |  |  |  | REG. NO. 01384 |  |
|---|--|------------------|--|--|--|---|--|---|--|---|--|--|--|--|--|-----------------------------------|--|---|--|---|--|---------------------|--|--|--|--|--|--|--|----------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>James E. Smith  |  |                  |  |  |  |   |  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR<br>1 1 19 83 |  |  |  |  |  |                                   |  |   |  | 2b. HOUR<br>M 11:40                     |  |                     |  |  |  |  |  |  |  |                |  |
| 3. SEX<br>male  |  | 4. RACE<br>Black |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>10 10 31  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS<br>51               |  | IF UNDER 1 YR. MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br>1 1 19 83   |  |  |  |                                   |  |   |  |   |  | 2d. HOUR<br>M 11:40 |  |  |  |  |  |  |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City                                       |  |  |  |                                   |  |   |  |   |  | MD                  |  |  |  |  |  |  |  |                |  |
| 12. CITY OR TOWN OF DEATH<br>Baltimore  |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Winchester & Stockton Streets |  |   |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |   |  |   |  |                     |  |  |  |  |  |  |  |                |  |
| 13a. STATE<br>Maryland  |  |                  |  | 13b. COUNTY  |  |   |  | 13c. CITY OR TOWN<br>Baltimore  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1108 Carrollton Ave. 21204                                |  |                                   |  |   |  |   |  |                     |  |  |  |  |  |  |  |                |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Willie Washington Smith  |  |                  |  |  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Laura Brokins                             |  |  |  |  |  |                                   |  |   |  |   |  |                     |  |  |  |  |  |  |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>No  |  |                  |  | (IF YES, GIVE WAR OR DATES)  |  |   |  | 16b. SOCIAL SECURITY NO.<br>228-34-0899   |  |   |  | 17. INFORMANT ADDRESS<br>Laura E. Gatling 3009 Thormdale Ave. Apt. 2                         |  |  |  |                                   |  |   |  |   |  |                     |  |  |  |  |  |  |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Shotgun wound of head</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |  |                  |  |  |  |   |  |   |  |   |  |  |  |  |  |                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH        |  |   |  |                     |  |  |  |  |  |  |  |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1  |  |                  |  |  |  |   |  |   |  |   |  |  |  |  |  |                                   |  |   |  |   |  |                     |  |  |  |  |  |  |  |                |  |
| 19a. DATE OF OPERATION  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  |   |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                   |  |   |  |   |  |                     |  |  |  |  |  |  |  |                |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>1:28 P.M. 1 1 19 83  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Subject was shot   |  |   |  |  |  |  |  |                                   |  |   |  |   |  |                     |  |  |  |  |  |  |  |                |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>School yard   |  |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br>Winchester & Stockton Sts., Balto., Md.   |  |   |  |  |  |  |  |                                   |  |   |  |   |  |                     |  |  |  |  |  |  |  |                |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |  |  |   |  |   |  |   |  |  |  |  |  |                                   |  |   |  |   |  |                     |  |  |  |  |  |  |  |                |  |
| ACTUAL SIGNATURE <i>Dennis F. Smyth</i>   |  |                  |  |  |  |   |  |   |  | TITLE (SPECIFY)<br>Assistant MEDICAL EXAMINER   |  |  |  |  |  |                                   |  |   |  | DATE SIGNED<br>1-1-83                   |  |                     |  |  |  |  |  |  |  |                |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Dennis F. Smyth, M.D.  |  |                  |  |  |  |   |  |   |  | ADDRESS<br>111 Penn Street  |  |  |  |  |  |                                   |  |   |  |   |  |                     |  |  |  |  |  |  |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  |                  |  | 23b. DATE<br>1/7/83  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mount Auburn Cem. |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Md.                                |  |  |  |  |  |                                   |  |   |  |   |  |                     |  |  |  |  |  |  |  |                |  |
| 24. FUNERAL DIRECTOR NAME<br>Wm. C. March F/H Inc.  |  |                  |  |  |  |   |  |   |  | ADDRESS<br>1101 E. north Avenue   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 4 1983                                      |  |                                   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Conner</i> |  |   |  |                     |  |  |  |  |  |  |  |                |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8301385

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |                              |   |  |
|---|--|---|--|---|------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LEROY - SMITH</b>                       |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 19, 1983</b> |   | 2b. HOUR<br><b>6:35 A.M.</b> |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 10, 1903</b>  |                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Hospital Corp.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Factory worker</b>   |                              | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Shoe factory</b>  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>- -</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                              | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Clifton - Smith ?</b>                |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>? unknown - ? -</b>   |  | 13e. STREET ADDRESS<br><b>1704 E. Pratt St.</b>   |                              | 21231   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b> |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>- -</b>   |  | 17. INFORMANT<br><b>Randolph Avry</b>   |                              | ADDRESS<br><b>2313 Eastern Ave.</b>   |  |

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **EXTENSION OF ACUTE MYOCARDIAL INFARCTION**

4100

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF

(c) \_\_\_\_\_

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c).

## MEDICAL CERTIFICATION

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>DECEMBER 20, 1982</b> to <b>JANUARY 19, 1983</b> , that (I) (we) lost<br>saw the deceased alive on <b>JANUARY 19, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>A. J. Helou, M.D.</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/19/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A. J. Helou, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL<br/>100 NORTH BROADWAY, BALTIMORE, MD 21231</b>   |  |  |  |

|   |  |                                   |  |   |  |   |  |
|---|--|-----------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                 |  | 23b. DATE<br><b>Jan. 24, 1983</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OakLawn Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Lilly &amp; Zeiler Inc. F.H. 1901 Eastern Ave.</b> |  |                                   |  | 25a. DATE OF BURIAL<br><b>JAN 26 1983</b>                     |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Smith</i>                      |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

July 10, 1903

White

Male

Baltimore City

X

United States

Maryland

Factory worker

Corp.

Church Hospital

Baltimore

104 E. Pratt St.

X

Baltimore

- -

Maryland

Unknown

Smith

-

Clifton

Residence 2111 Eastern Ave.

312-1-08

- -

NO

Handwritten signature or initials

Baltimore Co., Md.

JAN 28 1903

Ellis & Miller Inc. 7 E. 1st Eastern Ave.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 01386

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Margaret M Smith  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1/11/83                                |  | 2b. HOUR<br>9:51 A M   |
| 3. SEX<br>Female  | 4. RACE<br>Caucasian   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 17 06   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>6 13   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>USA.   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto City MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br>Balto  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SBC/H Haveres St Balto, MD. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY<br>Domestic  |  |
| 13a. STATE<br>Baltimore   |  |   | 13b. COUNTY<br>Balto  | 13c. CITY OR TOWN<br>Balto   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Willis - Smith  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Julia - A. Ross              |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>218-12-4752   |   | 17. INFORMANT<br>Therese M. Clark 215 Jeffrey St., Balto., MD. 21225                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (d).<br>4360 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (d), stating the underlying cause last.<br>(b) }<br>(c) }           |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 1/2 hrs<br>2 days<br>3 weeks   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1978, 19, to present, 19, that (I) (we) lost saw the deceased alive on 1/11/83 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |
| 22b. SIGNATURE<br>LISKOWICZ   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>LISKOWICZ  |  | 22e. ADDRESS<br>South Baltimore General Hospital  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>1/13/1983   | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, A. A. Co., Md.              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>McCully Funeral Homes   |  | Balto., Md. 21225<br>237 E. Patapsco Ave.,  |   | 25. DATE REC'D. BY REGISTRAR<br>JAN 13 1983  |  |

BP



20% COTTON

CHIEF MAN



Just before sunset

Handwritten notes at the bottom of the page, including "1000 ft" and "1000 ft" repeated.

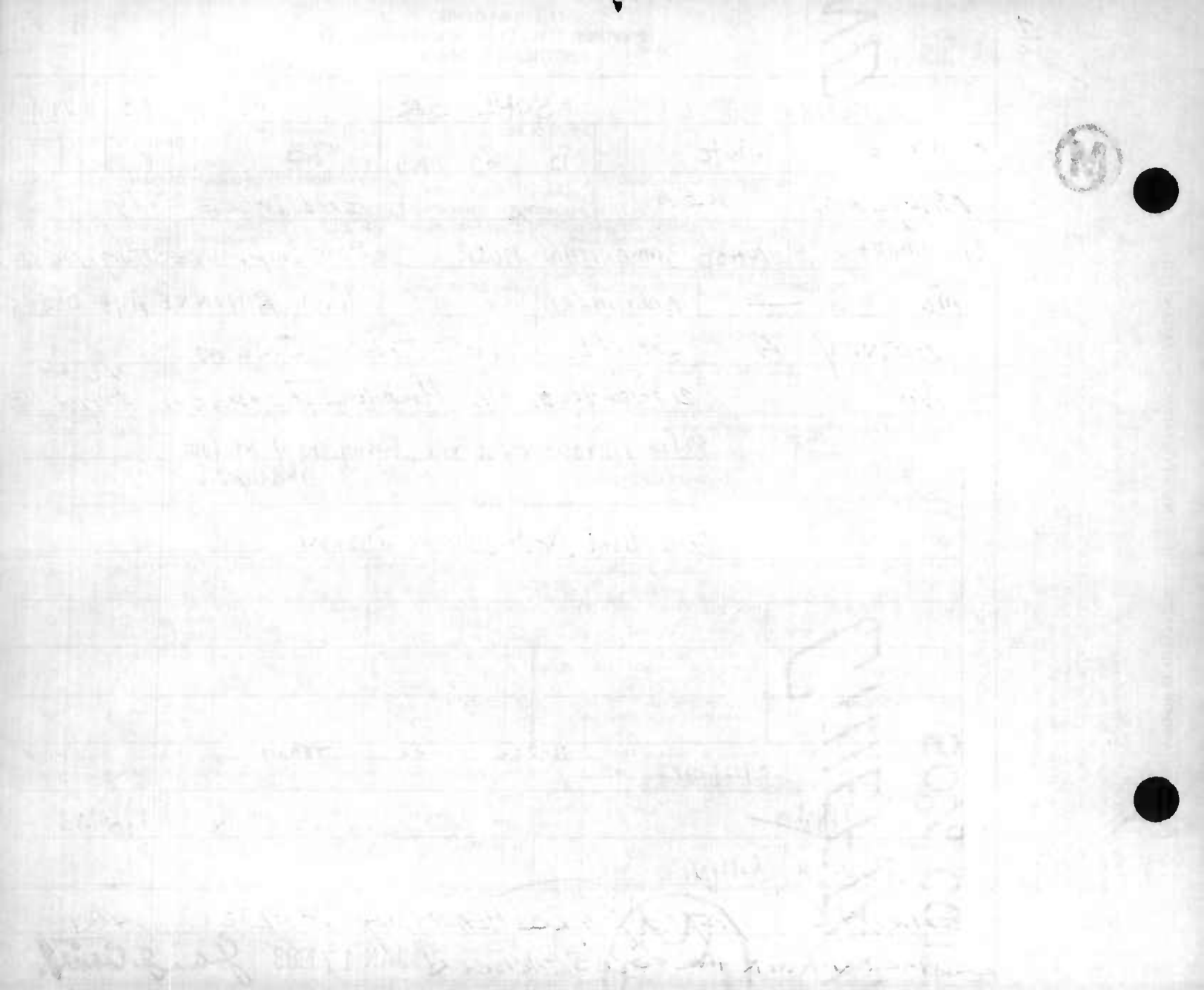
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 83 01387  |  |  |  |
|---|--|---|--|---|--|--|--|
| FOR<br>1. STATE<br>REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>HENRY L SOHL SR   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>01 12 83  |  |  |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 09 1909  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GOOD SAMARITAN HOSP. |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RET. Sup. WESTINGHOUSE  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13e. STREET ADDRESS<br>4604 BAYONNE AVE. 21206  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>HENRY A SOHL  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>NETTIE CRUM  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  |
| 16b. SOCIAL SECURITY NO.<br>213-10-4043   |  | 17. INFORMANT<br>ADDRESS<br>Mrs MICHAEL Thompson 4608 BAYONNE   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Pulm. Fibrosis & Hypoxia, Gangrene of Rt. foot and Sepsis.<br>4409<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Generalized Aortic-sclerotic Disease. |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-26-1982 to today 1983, that (I) (we) lost saw the deceased alive on 01/12/1983 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Rakesh Sahni  |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  | 22c. DATE SIGNED<br>1/12/83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RAKESH SAHNI   |  | 22e. ADDRESS  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(MARK IF)  |  | 23b. DATE<br>1/15/83  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>SACRED HEART MARY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO MD   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>LEONARD J. RUCK INC   |  | ADDRESS<br>5305 HARFORD   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 17 1983  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Conitt   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 3 8 3

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |   |
|---|--|--|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>BERNARD C. SOLOMON</b> |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01/30/83</b>                              |   | 2b. HOUR<br><b>3:50p</b>  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>NEGRO</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 5 36</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>46</b> YRS.                         | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>                               | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>         |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Huckster</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Self EMP.</b>   |
| 13a. STATE<br><b>MD.</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>                                     | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Solomon, Sr.</b>                  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Willie McDonald</b>             |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>     |  | 16b. SOCIAL SECURITY NO.<br><b>212-36-4001</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Willie Solomon 1833 E. Biddle St.</b> |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CARDIO-RESPIRATORY FAILURE**  
**5728**  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost  
(b) **HEPATIC FAILURE**  
DUE TO, OR AS A CONSEQUENCE OF  
(c) **SEPSIS**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

4 DAYS

4 DAYS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

**RENAL AND PULMONARY FAILURE**

|  |  |  |  |
|--|--|--|--|
| 19a. DATE OF OPERATION<br><b>JAN 24, 1983</b>  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>ESOPHAGEAL BLEEDING</b> | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)         | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |

22a. I certify that (I) (this hospital) attended the deceased from **JAN 28**, 19 **83**, to **JAN 30**, 19 **83**, that (I) (we) lost  
saw the deceased alive on **JAN 30**, 19 **83**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) did (did not) see the body after death.

|  |   |  |   |
|--|---|--|---|
| 22b. SIGNATURE<br><b>Craig Peters</b>                        | DEGREE<br><b>MD</b>                           | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br><b>JAN 30, 1983</b> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CRAIG PETERS</b> | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b> |  |   |

|   |                            |   |  |
|---|----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                         | 23b. DATE<br><b>2-4-83</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. PK.</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus MD.</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Randolph J. Collick 2431 E. Oliver St.</b> |                            | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 4 1983</b>            | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>              |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                  |  |   |  |   |  |   |  | REG. NO. 3 0 1 3 8 9  |  |
|--|--|------------------|--|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |                  |  |   |  |   |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>JOHN WESLEY SOLOMON  |  |                  |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR<br>1-28-83 |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Black |  | 5. DATE OF BIRTH (MONTH DAY YEAR)<br>8 12 20  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS.  |  | IF UNDER 1 YR. MONTHS DAYS  |  | 2c. DATE PRONOUNCED DEAD<br>1-28-83   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.C.  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                            |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2100 blk Llewelyn Avenue |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MD 13b. COUNTY  |  |                  |  | 13c. CITY OR TOWN<br>Baltimore  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>2125 Llewelyn Avenue 21213                                     |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Eugene Solomon  |  |                  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary Thone                                      |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>Yes  |  |                  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS<br>Paul Solomon 1704 Windemere Avenue                                   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>9654 IMMEDIATE CAUSE (a) Gunshot wound of neck<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |                  |  |   |  |   |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                  |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY HOUR AM MONTH DAY YEAR<br>6:40 PM 1-28-83   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject shot |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>street   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br>2100 blk. Llewelyn Ave. Baltimore, Maryland |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> TITLE (SPECIFY)<br>Assistant MEDICAL EXAMINER<br>ACTUAL SIGNATURE Margaret A. Korell, M.D. DATE SIGNED 1-29-83<br>EXAMINER'S NAME (TYPE OR PRINT) ADDRESS 111 Penn Street |  |                  |  |   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |                  |  | 23b. DATE<br>2/5/83   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Family Plot   |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Halifax Co.                                |  |
| 24. FUNERAL DIRECTOR NAME<br>Wm. C. March F/H  |  |                  |  |   |  | ADDRESS<br>1101 E. North Ave.   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 1 1983   |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Connel  |  |



RECEIVED

DAVID B. W.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                      |  |  |  |   |  |   |   | REG. NO. 01390   |  |
|---|--|----------------------|--|--|--|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>BEULAH E. SOMMERMAN  |  |                      |  |  |  |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>1-19-83 |   | 2b. HOUR<br>M                           |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White     |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11-26-07   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS.<br>75   |  | IF UNDER 1 YR.<br>MONTHS DAYS   |   | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>MEXI U.S.A.  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                     |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>524 N. Streeper Street |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY          |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>524 N. Streeper St. 21205  |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Henry George Gunther  |  |                      |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sophia Mary Herwig                             |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |  |                      |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-10-1943 D   |  | 17. INFORMANT<br>ADDRESS<br>Elaine Bell, 6407 Sefton Ave. 21214                                 |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF                               |  |                      |  |  |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |                      |  |  |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |   | 20. AUTOPSY (HEAD ONLY)<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |   |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |  |  |
| 22a. I certify that I took charge of the remains described above, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .<br>Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |                      |  |  |  |   |  |   |   |  |  |
| ACTUAL SIGNATURE<br><i>Margaret A. Koroll</i>   |  |                      |  |  |  | TITLE (SPECIFY)<br>M.D. Assistant   |  |   | MEDICAL EXAMINER<br>DATE SIGNED 1-19-83 |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Margaret A. Koroll, M.D.  |  |                      |  |  |  | ADDRESS<br>111 Penn Street  |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>1-22-83 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., Md.   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc., 5305 Harford Rd.   |  |                      |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 21 1983  |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Connel</i>   |   |  |  |



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A.B. 7.11

Stamens

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 3 0 1 3 9 1  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.   |  |  |  |
| I. DECEASED NAME<br>(TYPE OR PRINT)<br><b>EDWARD MILTON SPENCE</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JANUARY 3, 1983</b>   |  |  |  |
| 3 SEX<br><b>MALE</b>  |  | 4 RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAY 20, 1902</b>  |  | 2b. HOUR<br><b>3:50 PM</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 12b. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED MANAGER</b>                                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>606 BRAESIDE ROAD 21229</b>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214-01-5089 A</b>   |  | 17. INFORMANT ADDRESS<br><b>MRS. FRANCES C. SPENCE SAME AS # 13</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4100</b> IMMEDIATE CAUSE (a) <u>Myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Coronary artery disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Atherosclerotic heart disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>Diabetes mellitus</u>  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>January 21</u> , 19 <u>83</u> , to <u>January 3</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>January 1</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>John Barnaby M.D.</i>  |  |  |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4 Jan 83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN BARNABY M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>1652 E. BELVEDERE, BALTIMORE, MD. 21239</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>1/6/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WOODLAWN CEMETERY</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>WOODLAWN MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WITZKE P.A.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 7 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Conner</i>  |  |
| 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228   |  |  |  |  |  |  |  |



NAME

WHITE

MAY 28, 1963

ON

2, 1963

JANUARY

SPRING

WINTER

SUMMER

MAY 1963

1963

1963

BALTIMORE

ST. LOUIS HOSPITAL

RETIRED MANAGER

MAY 1963

BALTIMORE

800 UNIVERSITY ROAD

CHICAGO

CHICAGO

CHICAGO

NO

21 - 1963

MRS. FRANKLIN D. ROOSEVELT

RECEIVED

1963

AMERICAN CEMENT

AMERICAN

MAY 1963

1900 KENNEDY AVENUE, CATONSVILLE, MD. 21228

WATER P.A.

JAN 1963

1963

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called upon.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 3 0 1 3 9 2   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LILLIAN GLADYS SPITTLE</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>01 02 83</b>   |  | 2b. HOUR<br><b>A M</b>   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>09 19 03</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79 YRS.</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2038 GRIFFISS AVENUE</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>  |  | 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>---</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>2038 GRIFFISS AVENUE, 21230</b>   |  |   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>WILLIAM BAUER</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>MARY WALTHER</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>214-03-6735</b>  |  | 17. INFORMANT ADDRESS<br><b>GEORGE GROIN 1233 S. GRANTLEY ST., 21229</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Atherosclerotic Cardiovascular</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>30 minutes</b><br><b>3 years</b> |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Jeffrey Cole M.D.</b>   |  |   |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>1/3/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JEFFREY COLE, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>ST. AGNES HOSPITAL, 900 S. CATON AVENUE</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>01-05-83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b>  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 5 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   | 8 3 0 1 3 9 3  |  |   |  |  |  |  |
|--|--|--|--|---|--|--|---|--|--|--|--|
| 1- FOR STATE REGISTRAR   |  |  |  |   | REG. NO.   |  |   |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>EDWARD LEE SPRUIELL   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>1 2 83   |  |   |  |  | 2b. HOUR<br>11:03AM                          |  |
| 3. SEX<br>male   |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 6 31  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>51 YRS.                 |   | IF UNDER 1 YEAR<br>MONTHS DAYS                           |  | IF UNDER 24 HRS<br>HOURS MIN.                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N. Carolina   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VAMC, Baltimore, Maryland 21218 |  |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| 13a. STATE<br>Maryland   |  |  |  |   | 13b. COUNTY<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1222 Rolling Rd. 21207  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Asa Tom Lavier   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Eva Spruill   |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>246-40-9627 |   | 17. INFORMANT ADDRESS<br>Eva Spruill 1222 Rolling Rd   |  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>1509 IMMEDIATE CAUSE (a) <u>esophageal Cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |   |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>DECEMBER 26</u> , 19 <u>82</u> , to <u>JANUARY 2</u> , 19 <u>83</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>JANUARY 2</u> , 19 <u>83</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death. |  |  |  |   |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br><u>Darla S. Holland, M.D.</u>  |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED<br><u>1/3/83</u>                        |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>DARLA S. HOLLAND, M.D.</u>   |  |  |  |   | 22e. ADDRESS<br>VAMC, BALTIMORE, MARYLAND 21218  |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |  | 23b. DATE<br>1/7/83  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. Nat. Mem. Pk.  |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Laurel Md. |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Wm. C. March F/H Inc. 1101 E. north avenue   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 4 1983  |  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Connel</u>   |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 3 0 1 3 9 4   |  |  |   |
|---|--|---|--|---|--|--|---|
| FOR<br>1. STATE 2-10-83cn<br>REGISTRAR  |  |   |  | CERTIFICATE OF DEATH  |  |  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  | 2a. DATE OF DEATH   |  |  |   |
| FIRST MIDDLE LAST   |  |   |  | MONTH DAY YEAR HOUR   |  |  |   |
| Baby Girl Squirrel  |  |   |  | 11/31/83 830 A.M.   |  |  |   |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |   |
| Female  |  | B   |  | MONTH DAY YEAR<br>1 31 83   |  | newborn YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |   |
| MD NJ   |  | NJ USA  |  |   |  | Baltimore City MD.   |   |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |   |
| B. Hinner   |  | Univ Md Hosp  |  | newborn   |  | newborn  |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13d. INSIDE CITY LIMITS?  |  |  |   |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN  |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |   |
| MD NA BALTIMORE   |  |   |  | 13e. STREET ADDRESS   |  |  |   |
|   |  |   |  | 1728 N Fulton ave 21217   |  |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |  |   |
| Robt Krumm  |  |   |  | Belva Squirrel  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS   |  |  |   |
| NA  |  | 205912000   |  | 1728 N Fulton Ave   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:  |  |   |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| 7651 IMMEDIATE CAUSE (a) Prematurity  |  |   |  |   |  |  |   |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |  |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |  |   |  |  |   |
| (b) nonviable fetus   |  |   |  |   |  |  |   |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |  |   |
| (c)   |  |   |  |   |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.0   |  |   |  |   |  |  |   |
| NA  |  |   |  |   |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |   |
|   |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
|   |  |   |  |   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |   |
| 22b. SIGNATURE  |  |   |  | DEGREE  |  | 22c. DATE SIGNED   |   |
| Alan Sill MD  |  |   |  | MD  |  |  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e. ADDRESS  |  |  |   |
| ALAN SILL MD  |  |   |  | Univ Md Hosp Dept of Ped  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                     |   |
| Removal   |  | 2/2/83  |  |   |  |  |   |
| 24. FUNERAL DIRECTOR<br>NAME  |  |   |  | ADDRESS   |  |  |   |
| Anatomy Board   |  |   |  | Balto., Md.   |  |  |   |
| DATE REC'D BY REGISTRAR   |  |   |  | REGISTRAR'S SIGNATURE   |  |  |   |
| FEB 7 1983  |  |   |  | John J. Conner  |  |  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 3 0 1 3 9 5  |  |
|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Charlotte E. Stanton</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>January 17, 1983</b>                                  |  | 2b. HOUR<br><b>8:35PM</b>                    |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Feb. 22, 1908</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS<br><b>74</b> YRS. MONTHS DAYS HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Bookkeeper</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY            |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  | 13a. STREET ADDRESS <b>21214</b>   |  |  |
| 13a. STATE<br><b>Maryland</b>  | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Calvin M. Wolf</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Charlotte Elliott</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>283-05-6381</b>   |  | 17. INFORMANT ADDRESS<br><b>Agnes Birkmaier 3207 E. Northern Parkway</b>                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1991</b> IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Suspected Metastatic Malignancy Primary</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>Unknown</b><br>(c) |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                           |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (X) (his hospital) attended the deceased from <b>January 12, 19 83</b> , to <b>January 17, 19 83</b> , that (X) (we) lost saw the deceased alive on <b>January 17, 19 83</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did not view the body after death.   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>K. Trent M.D.</b>   |  | DEGREE   |  | 22c. DATE SIGNED<br><b>1/17/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Karen Trent, M.D.</b>  |  | 22e. ADDRESS<br><b>C/O Maryland General Hospital</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>Jan. 18, 1983</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount Crematory</b>                                       |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 18 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Gierke</b>  |  |

BP 13



Pennsylvania

U.S.A.

X

bookkeeper

Maryland

Baltimore

X

1907 - Northern Railway

Calvin

M.

1907

Charlotte

Illinois

22-05-1911 Ames Director 1907 - Northern Railway

Generation

Leonard J. Luck, Inc. Baltimore, Maryland

Jan. 18, 1907 Green Mount Cemetery Baltimore

Maryland

Jan 18 1907

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 01396

FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MARY W. STANTON  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 4, 1983                        |   | 2b. HOUR<br>5:30 A M   |
| 3. SEX<br>Female  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec. 27, 1887   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>95 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>700 N. Charles St. Apt. 4A |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home   |  |
| 13a. STATE<br>Maryland  |   | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>700 N. Charles St., 21201   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Samuel S. Wallace   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ann Tindell                  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>220 44 4555   | 17. INFORMANT<br>ADDRESS<br>Mrs. Henry W. Byrne, Same                         |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4292 DUE TO, OR AS A CONSEQUENCE OF 650 D<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>(c) _____ |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 yrs   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) _____  |   |   |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-15, 19 88, to 1/4, 19 83, that (I) (we) lost saw the deceased alive on 5-22-81, 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.             |   |   |   |   |  |
| 22b. SIGNATURE<br>Franklin E. Leslie  |   | DEGREE<br>M.D.  |   | 22c. DATE SIGNED<br>1/4/83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Franklin E. Leslie, M. D.  |   | 22e. ADDRESS<br>3501 St. Paul St., Balto., MD   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>1/6/83   | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., MD  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., MD 21212  |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 6 1983   |   | 25b. REGISTRAR'S SIGNATURE<br>John J. Conner  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a necropsy performed.



| 1. FOR STATE REGISTRAR  |                  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  | REG. NO. 83 01397   |  |
|---|------------------|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Thelma E STANTON</i>  |                  | 20. DATE OF DEATH MONTH DAY YEAR <i>1-16-83</i>   |  | 2b. HOUR <i>7:30</i> M  |  |
| 3. SEX <i>F</i>   | 4. RACE <i>B</i> | 5. DATE OF BIRTH MONTH DAY YEAR <i>10-8-25</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <i>57</i> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Mont. Pleasant PA.</i>   |                  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore</i> MD.   |  |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i>  |                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>5000 Midwood Ave.</i> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>House Wife</i>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 30a. STATE <i>Maryland</i> 13b. COUNTY <i>Baltimore</i>  |                  | 13c. CITY OR TOWN <i>Baltimore</i>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <i>5000 Midwood Ave.</i> 21212   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>D. J. McQuarrie</i>  |                  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Blanche Brown</i>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i> 16b. SOCIAL SECURITY NO. <i>169-22-1240</i> 17. INFORMANT ADDRESS <i>William H. Stanton 5000 Midwood Ave.</i>                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>1749 IMMEDIATE CAUSE (a) <i>respiratory arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>hypoxia</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>breast cancer</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs.</i>             |                  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                  |   |  |   |  |
| 19a. DATE OF OPERATION  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Sept</i> 19 <i>81</i> , to <i>Jan</i> 19 <i>83</i> , that (I) (we) lost saw the deceased alive on <i>Jan</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                  |   |  |   |  |
| 22a. SIGNATURE <i>A. Gillette</i>   |                  | DEGREE <i>MD</i>  |  | 22b. DATE SIGNED <i>1/17/83</i>   |  |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT) <i>A. Gillette</i>  |                  | 22e. ADDRESS  |  | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (OFFICIAL) <i>Burial</i>  |                  | 23b. DATE <i>1-21-83</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY <i>Midwood New Pk</i>  |  |
| 23d. FUNERAL DIRECTOR NAME <i>William J. Sperry</i>   |                  | ADDRESS <i>1639 N. Broadway</i>   |  | 23e. LOCATION CITY OR TOWN <i>Towson</i> COUNTY <i>Maryland</i> STATE <i>Md</i>   |  |
| 24. FUNERAL DIRECTOR NAME <i>William J. Sperry</i>  |                  | ADDRESS <i>1639 N. Broadway</i>   |  | 25a. DATE REC'D. BY REGISTRAR <i>JAN 18 1983</i> REGISTRAR'S SIGNATURE <i>John J. Calkins</i>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP \_\_\_\_\_

DHMM - 16 50M 4/82  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 3 0 1 3 9 8  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HELEN M. STEGMAN</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JANUARY 21, 1983</b>  |  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>MAY 19, 1887</b>   |  | 2b. HOUR<br><b>9:05 PM</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>95</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>322 TUNBRIDGE RD.</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>  |  |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>EDUCATOR</b>   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>PUBLIC SCHOOLS</b>   |  |  |  |
| 13a. STATE<br><b>MD</b>  |  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>JOHN HENRY STEGMAN</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>ANNA ?</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>220-44-0862</b>   |  | 17. INFORMANT ADDRESS<br><b>J. RICHARD OCONNELL 10 LIGHT ST. 21202</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b><br><b>years</b> |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Degenerative Arthritis</b>  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>December 61</b> to <b>Jan 21</b> 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>Dec 23</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>J. Frank Supplee, Jr.</b>   |  |  |  | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>Jan 22, 1983</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. Frank Supplee, Jr.</b>  |  |  |  | 22e. ADDRESS<br><b>201 E University Pkwy, Balt, Md 2120</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>JAN. 24, 1983</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WOODLAWN CEM.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>WOODLAWN BALTIMORE MD.</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>MITCHELL-WIEDEFELD HOME</b>  |  |  |  | ADDRESS<br><b>6500 YORK RD. 21212</b>  |  | 25a. DATE REC'D. BY REGISTRAR BY REGISTRAR'S SIGNATURE<br><b>JAN 26 1983 John J. Calver</b>                                |  |





FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |                     |  |  |   |  |  |  |  |  |             |  |
|--|--|--|--|---|---------------------|--|--|---|--|--|--|--|--|-------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>WALTER M. STEIN   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>01-27-83 |   | 2b. HOUR<br>1:55 PM |  |  |   |  |  |  |  |  |             |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>06 25 1907  |                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS   |  | 8. IF UNDER 24 HRS.<br>HOURS MIN.  |  |  |  |             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NEW YORK  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                     |  |   |  |  |  |  |  |             |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>LEVINDALE |  |   |                     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MANUFACTURER               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>SHOES  |  |  |  |  |  |             |  |
| 13a. STATE<br>MARYLAND   |  |  |  |   |                     | 13b. COUNTY<br>BALTO.  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  | 13e. STREET ADDRESS<br>3201 OLD POST DR., APT. 3 |  | 13f. #21208 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>AARON STEIN  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br>BERTHA STILLMAN   |                     |  |  |   |  |  |  |  |  |             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NAME OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO   |  |  |  | 16b. SOCIAL SECURITY NO.<br>216-09-1777   |                     | 17. INFORMANT<br>ADDRESS<br>MRS. DOROTHY M. STEIN APT. 3<br>3201 OLD POST DR. BALTO., MD 21208 |  |   |  |  |  |  |  |             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>4100 IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCT,<br>DUE TO, OR AS A CONSEQUENCE OF<br>ANT. LATERAL<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) ISCHEMIC HEART DISEASE<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>12 HRS<br>YEARS |  |  |  |   |                     |  |  |   |  |  |  |  |  |             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>ALZHEIMER'S DISEASE   |  |  |  |   |                     |  |  |   |  |  |  |  |  |             |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                     |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                     |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |             |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                     |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-27-83, to 1-27-83, that (I) (we) lost saw the deceased alive on 1-27-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |                     |  |  |   |  |  |  |  |  |             |  |
| 22b. SIGNATURE<br>B. ZAW-WIN   |  |  |  |   |                     | DEGREE<br>MD   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>1-27-83  |  |  |  |             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>B. ZAW-WIN  |  |  |  |   |                     | 22e. ADDRESS<br>LEVINDALE GERIATRIC CTR 21215  |  |   |  |  |  |  |  |             |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) BURIAL  |  |  |  | 23b. DATE<br>JAN. 30, 1983  |                     | 23c. NAME OF CEMETERY OR CREMATORY<br>BETH TFILOH  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND  |  |  |  |  |  |             |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SOL LEVINSON & BROS  |  |  |  |   |                     | ADDRESS<br>6010 REBASTIAN RD   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 1 1983   |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Glick  |  |  |  |             |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

RECEIVED  
FEB 1 1963  
U.S. AIR FORCE



FEB 1 1963



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |   |   |  |  |  |
|--|--|---|--|---|---|---|--|--|--|
| FOR<br>1- STATE REGISTRAR  |  |   |  |   | REG. NO. 8301400  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MAUDE S STEINACKER</b>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 20, 1983</b>                                  |   |  | 2b. HOUR<br><b>5:12 PM</b>   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 4 1903</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.                                       |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                       |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST AGNES Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(1. TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE <b>MARYLAND</b> 13c. COUNTY <b>BALTO</b>  |  |   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>4048 Wilkens Ave</b> 21229 |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George J Smith</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Maude V Pedrick</b>                         |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>214-01-9232</b>  |  | 17. INFORMANT ADDRESS<br><b>Elwood Steuacker - 826 Providence Rd 21204</b>  |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pulmonary edema</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Atherosclerotic coronary vascular disease</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>24 hours</b><br><b>years</b> |  |   |  |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>               |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not view the body after death.)  |  |   |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Gregory F. McAuliffe, MD</b> DEGREE<br>22c. ADDRESS<br><b>BALTIMORE</b>   |  |   |  |   |   | 22c. DATE SIGNED<br><b>1.20.83</b>  |  |  |  |
| 23a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE</b>   |  | 23b. DATE<br><b>1-24-83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>  |   | 23d. LOCATION<br>CITY OR TOWN STATE<br><b>BALTIMORE Maryland</b>                        |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Farley Funeral Home - 6601 Frederick Ave</b>  |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 26 1983</b>                                     |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. [Signature]</b>   |  |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM RM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
20M 4/B2

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                     |  |   |  |   |   |   |                         | REG. NO.  |  |
|--|--|---------------------|--|---|--|---|---|---|-------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Lloyd J. Steward</b>  |  |                     |  |   |  |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1 6 1983</b> |   | 2b. HOUR<br>M <b>10</b> |   |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>B</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>3 - 18 - 28</b>   |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY) <b>54</b> YRS.   |   | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |                         | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>1 6 1983</b>                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  |                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD                               |                         |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                     |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1232 N. Gilmore Street</b> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |                         | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>MD</b>  |  |                     |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>BALTO</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                         | 13e. STREET ADDRESS<br><b>1232 N. Gilmore St. 21217</b>                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Lloyd Stewart</b>   |  |                     |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Curtis</b>  |   |   |                         |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>UNKNOWN</b>   |  |                     |  | 16b. SOCIAL SECURITY NO.<br><b>214-30-3364</b>  |  | 17. INFORMANT<br><b>Alma Tucker</b>   |   |   |                         | ADDRESS<br><b>3110 Woodlawn Ave</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Ethanol Intoxication</b><br><b>3030</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |  |                     |  |   |  |   |   |   |                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                     |  |   |  |   |   |   |                         |   |  |
| 19a. DATE OF OPERATION   |  |                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |   |   |                         | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |   |                         |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE  |   |   |                         |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                     |  |   |  |   |   |   |                         |   |  |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth</i>   |  |                     |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER  |  |   |   | DATE SIGNED<br><b>1-7-83</b>  |                         |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>Dennis F. Smyth, M.D.</b>  |  |                     |  | ADDRESS<br><b>111 Penn Street</b>   |  |   |   |   |                         |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |                     |  | 23b. DATE<br><b>1-14-83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>KING MEM. PARK</b>   |   |   |                         | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Randallstown MD</b>                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>VERNON R. Bailey</b>  |  |                     |  | ADDRESS<br><b>1348 N. Calhoun St. 21217</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 13 1983</b>   |                         | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Connor</i>                                 |  |

RECEIVED  
JAN 10 1964  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |   |  |  |  |  |
|--|--|--|--|---|---|--|--|--|--|
| 1 - STATE REGISTRAR  |  |  |  |   | REG. NO.  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mary E. Stewart</b>  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 20 83</b>   |  |  | 2b. HOUR<br><b>5:05pm</b>  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 16 18</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>St. Agnes Hospital<br/>Baltimore City</b> MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>clerk</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>bakery</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b>  |  |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1817 Clarke Blvd. 21227</b>                          |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John J. Walsh</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Margaret Ogden</b>                     |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b> (IF YES, GIVE WAR OR DATES) -----   |  |  |  |   | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>ADDRESS<br><b>Mr. Robert P. Stewart, Sr. 1817 Clarke Bld.</b> |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4100 Pulmonary edema</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) -----<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |  |  |   |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>S/P Fracture of vertebra.</b>  |  |  |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-20-</b> 19 <b>83</b> , to <b>1-20-</b> 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>1-20-</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.      |  |  |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>George J. Vellani</b>   |  |  |  | DEGREE<br><b>MD</b>   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1-20-83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>G. VELLANIKARAN MD</b>   |  |  |  | 22e. ADDRESS<br><b>St. Agnes Hospital</b>   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/24/83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore City Maryland</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ambrose Funeral Home 1328 Sulphur Spring Rd.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 21 1983</b>   |   |  |  |  |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carlin</b>   |   |  |  |  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 83 01403   |  |
|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Paige Elizabeth Stinson   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 29 83<br>2b. HOUR<br>3:40 PM                |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 7 30   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>52 YRS.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                        |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1340 E. Fayette Street                            |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Baltimore   |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>1340 E. Fayette St. 21231  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Dennis Carter  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lula Brown   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>216-36-5726   |  | 17. INFORMANT<br>ADDRESS<br>Chester L. Stinson 1340 E. Fayette St.                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>SMALL CELL CANCER OF LUNG</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/1</u> , 19 <u>82</u> , to <u>1/29</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>1/29</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Thomas D. Brown</u>   |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>2/1/83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>THOMAS D. BROWN   |  | 22e. ADDRESS<br>Johns Hopkins Oncology CTR<br>600 N Wolfe St. Balt. MD  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>2/3/83   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mount Calvary Cem                              |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. Md.  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H Inc.  |  | ADDRESS<br>1101 E. North Ave  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 1 1983  |  |
|  |  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Lohr</u>   |  |  |  |



U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY



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NOV 15 1915

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                |  |   |   |   |   |  |   |  | REG. NO. 3 01404 |  |
|---|----------------|--|---|---|---|---|--|---|--|------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>BERNEST D. STOKELING, Jr.  |                |  |   |   |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> 1-29-83 19             |  | 2b. HOUR<br>PM 11:49  |  |                  |  |
| 3. SEX<br>M   | 4. RACE<br>Blk | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 5 1962   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>20 YRS.                         | 7. IF UNDER 1 YR.<br>MONTHS DAYS  | 8. IF UNDER 24 HRS.<br>HOURS MIN.   | 2c. DATE PRONOUNCED DEAD<br>1-29-83 19  |  | 2d. HOUR<br>PM 11:49  |  |                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  |                | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |   |  |                  |  |
| 11. CITY OR TOWN OF DEATH<br>Baltimore  |                | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital S.T.U. |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                  |  |
| 13a. STATE<br>Md.   |                | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>BALTO.   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>541 Bloom ST. 21217  |  |                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Bernest D. Stokeling, Sr.   |                |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Betty J. Grays   |   |   |  |   |  |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |                |  |   | 16b. SOCIAL SECURITY NO.<br>213-86-3391   |   | 17. INFORMANT<br>ADDRESS<br>Mrs. Betty J. Burton - 541 Bloom ST.                                |  |   |  |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple injuries<br>8151<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |                |  |   |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |                |  |   |   |   |   |  |   |  |                  |  |
| 19a. DATE OF OPERATION  |                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                     |   |   |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>11:20PM 1-29-83    |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>passenger of auto which struck a cement wall ejecting subject - head struck a fire hydrant |   |  |   |  |                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>street |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>2500blk. Druid Hill Ave. Baltimore, Maryland   |   |  |   |  |                  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> |                |  |   |   |   |   |  |   |  |                  |  |
| ACTUAL SIGNATURE<br>Margarita A. Korell   |                |  |   | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER  |   |   |  | DATE SIGNED<br>1-30-83  |  |                  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Margarita A. Korell, M.D.   |                |  |   | ADDRESS<br>111 Penn Street  |   |   |  |   |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |                |  | 23b. DATE<br>23-83  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. Md. |   |  |                  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>JAS. A. MORTON & SONS   |                |  |   |   |   | ADDRESS<br>1701 LAURENS   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 31 1983  |  |                  |  |
|   |                |  |   |   |   | 25b. REGISTRAR'S SIGNATURE<br>John J. Canine  |  |   |  |                  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copy papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 4 0 5

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |  |   |  |
|--|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>OLA B. STOKES   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JANUARY 18, 1983 |   |  | 2b. HOUR<br>4:37 <sup>M</sup>   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Black  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 22 31  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>41 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>THE JOHNS HOPKINS HOSPITAL |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |
| 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |   |   |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland |  |   |   | 13b. CITY OR TOWN<br>Baltimore  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Booker   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Parkie Brightwell  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Unknown  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A                        |   | 17. INFORMANT<br>ADDRESS<br>Shirley Booker 1804 N. Bond Street  |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

3030 IMMEDIATE CAUSE (a) Cardiopulmonary arrest  
DUE TO, OR AS A CONSEQUENCE OF  
(b) Electrolyte abnormalities  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  
(c) Alcohol abuse

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH WIDOWED BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 16

MEDICAL CERTIFICATION

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>[Signature]</i> MD   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>1/18/83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Gelman   |  |  |  | 22e. ADDRESS<br>JHH  |  |  |  |

|  |  |                      |  |   |  |  |  |
|--|--|----------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                     |  | 23b. DATE<br>1/21/83 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlington Nat. Cem. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arlington Va |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. march F/H Inc. 1101 E. North Avenue |  |                      |  | 25a. DATE REC'D. BY REGISTRAR<br>1983                     |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>           |  |

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

WASHINGTON, D. C.

OFFICE OF THE CHIEF OF BUREAU



U.S. GOVERNMENT PRINTING OFFICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

83 01406

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Ethel Newhan Stone</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1-19-83</b>                                 |   | 2b. HOUR<br><b>8 P<sup>M</sup></b>   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 26 1896</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Wesley Home Inc.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>Md</b>   |  | 13b. COUNTY<br><b>-</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>2211 W. Rogers Avenue 21209</b>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>J Arthur Newhan</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ida Grissith</b>               |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>216-03-4922</b>   |  | 17. INFORMANT ADDRESS<br><b>The Wesley Home 2211 W. Rogers Ave. 21209</b>                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>days</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>0</b>   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Daniel J. Winn</b>   |  | DEGREE<br><b>CO</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/20/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Daniel J. Winn</b>  |  | 22e. ADDRESS<br><b>2211 W. Rogers Ave -</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/22/83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>                               |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Pikesville Balto Co Md</b>   |  | 23e. DATE REC'D BY REGISTRAR 23f. REGISTRAR'S SIGNATURE<br><b>JAN 21 1983 John J. Conner</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Burgee Funeral Home</b>  |  | ADDRESS<br><b>3631 Falls Rd. 21211</b>   |  |   |  |

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1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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may be retained by the hospital or attending physician. The law requires that the body be retained for 24 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 are to be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 01407

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |   |  |   |  |  |  |
|---|--|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MADELYNE J STONE</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-22-83</b>                   |   |   | 2b. HOUR<br><b>11:37 AM</b>  |   |  |  |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>W</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 20 1919</b>  |   | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>63</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD.  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE RESIDENCE ADDRESS)<br><b>U. OF MD HOSPITAL</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. STATE<br><b>MD</b>   |  |  | 13b. CITY OR TOWN<br><b>PASADENA</b>                                    |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS<br><b>754 217th St. 2122</b>          |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN SKARDA</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>BARBARA POKORNY</b> |   |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>UNK</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>220-07420</b>                            |   | 17. INFORMANT<br><b>DONALD L. STONE JR.</b>   |  |   |  | ADDRESS<br><b>13079 21043 WILLIAMFIELD DR.</b> |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b><br>1749<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>STAPH AUREUS SEPSIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>BREAST CARCINOMA</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 HOURS</b><br><b>5 DAYS</b><br><b>2 YEARS</b> |  |  |   |   |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>1-22-83</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                        |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>            |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <b>1980</b> , 19 <b>82</b> , to <b>JAN 22</b> , 19 <b>83</b> , that (b) (we) saw the deceased alive on <b>JAN 22</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (c) (we) did not view the body after death.   |  |  |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>So, m</b>  |  |  | DEGREE  |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1/22/83</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>So</b>  |  |  | 22e. ADDRESS<br><b>22 S GREENE ST. BALTO, MD.</b>                       |   |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>1-26-83</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GLENHAVEN MEM.</b>                                     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY<br><b>BALTO. MD.</b> |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>HOFFMANN-SKARDA</b>  |  |  |   |   | 25. DATE REC'D BY REGISTRAR<br><b>JAN 25 1983</b>   |  | 26. REGISTRAR'S SIGNATURE<br><b>John J. Canine</b>        |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 4 0 8

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |   |  |  |  |
|---|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>SOPHIE STONER</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01 18 83</b>  |  | 2b. HOUR<br><b>9 20 A M</b>  |  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 18, 1897</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Gas, &amp; Electric</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY            |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   | 13b. COUNTY<br><b>---</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>21230 1219 Riverside Ave. Balto. Md.</b>   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Collins</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>219-20-7170A</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Mr. Harvey Stoner, 2 Baltimore Ave. Glen Burnie Md. 21061</b>   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ventricular Arrhythmia</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Respiratory Center Malfunction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Cerebrovascular Accident</b><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.<br><b>Congestive Heart Failure</b>  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |
| 22a. I certify that (if (this hospital) attended the deceased from <b>1/17</b> , 19 <b>83</b> , to <b>1/18</b> , 19 <b>83</b> , that (we) last saw the deceased alive on <b>1/17</b> , 19 <b>83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If well (did) not view the body after death.  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Robert A. Miller M.D.</b>  |   | DEGREE  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/18/83</b>           |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT A. MILLER, M.D.</b>  |   |   | 22e. ADDRESS<br><b>201 E. UNIVERSITY PARKWAY</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>Jan. 20, 1983</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>                                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>McCutty Funeral Home, 130 E. Fort Ave. Balto. Md.</b>  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 19 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Smith</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Page 10



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2/15/12

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**CENTRAL**

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER MUST EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOUR FILES AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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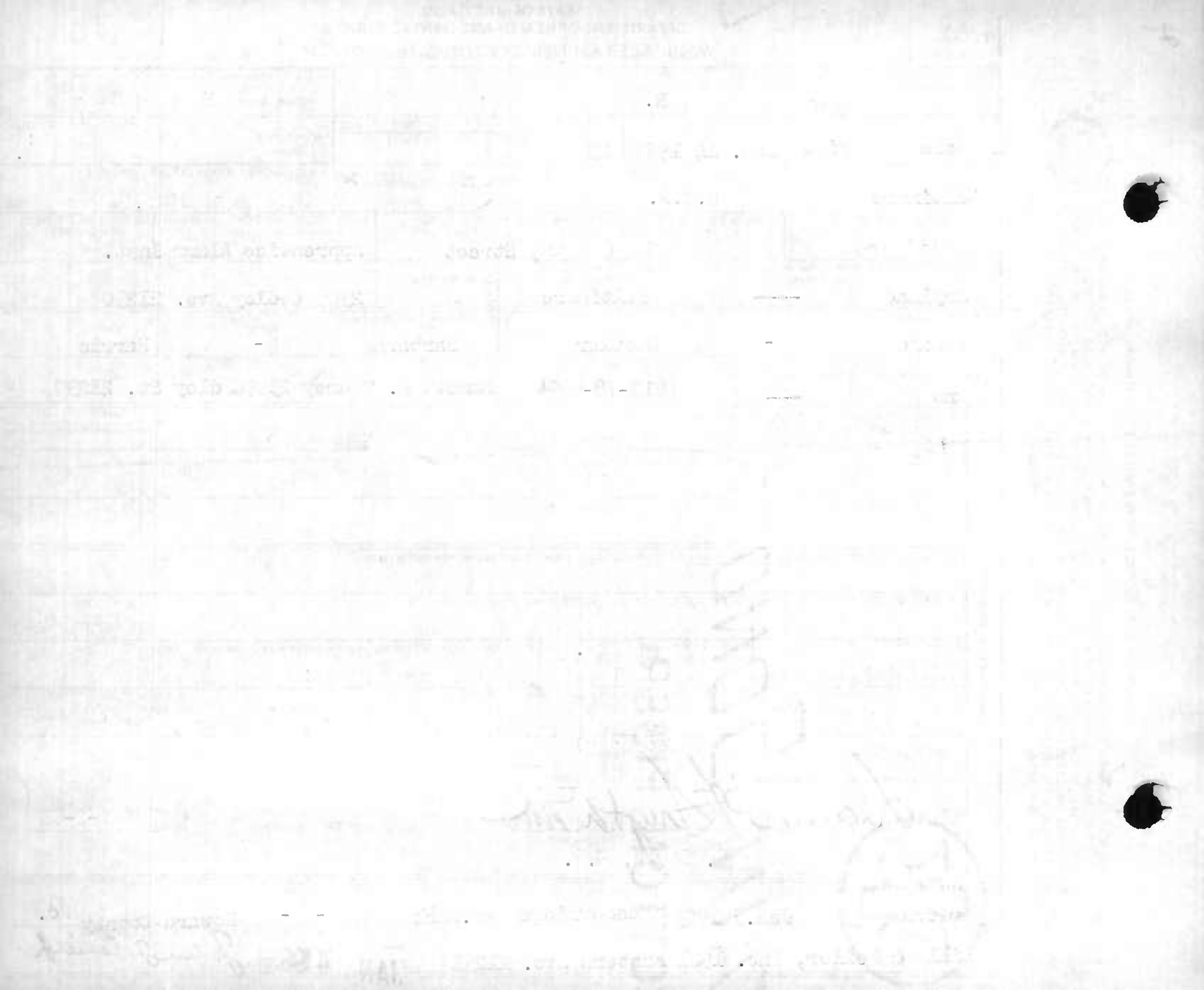
DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |                          |  |   |  |   |  |  |  |
|---|--|--------------------------|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Gary R. Stotler   |  |                          |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br>1 1 1983  |  |   |  | 2b. HOUR<br>M<br>8:14 a.m.   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White         |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 14 1959  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br>23   |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore  |  |                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |                          |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2309 Cedley (Avenue) Street |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Apprentice Alarm Inst.  |  |
| 13a. STATE<br>Maryland  |  |                          |  | 13b. COUNTY<br>---  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Donald - Stotler  |  |                          |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Barbara - Harris   |  |   |  | 16. SOCIAL SECURITY NO.<br>219-78-4994   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>no   |  |                          |  | 16b. SOCIAL SECURITY NO.<br>219-78-4994   |  |   |  | 17. INFORMANT<br>ADDRESS<br>Emmett F. Toomey 2309 Cedley St. 21230   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>9550 IMMEDIATE CAUSE (a) Gunshot wound of Head (handgun)<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF                                   |  |                          |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                          |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 20. AUTOPSY?<br>(head only)<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                          |  | 21b. TIME OF INJURY (est.)<br>HOUR A.M. MONTH DAY YEAR<br>? P.M. 1 1 1983   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject shot himself |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |  |                          |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>Home   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>2309 Cedley Avenue, Baltimore, Maryland          |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                          |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br>Dennis F. Smyth, M.D.   |  |                          |  | TITLE (SPECIFY)<br>Assistant  |  |   |  | MEDICAL EXAMINER<br>DATE SIGNED<br>1-2-83  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Dennis F. Smyth, M.D.   |  |                          |  | ADDRESS<br>111 Penn Street  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>Jan. 5 1983 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem. Park   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>- - Howard County Md.  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Lilly & Zeiler, Inc.  |  |                          |  | ADDRESS<br>1901 Eastern Ave. 21231  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 4 1983  |  |
|   |  |                          |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Conish  |  |   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 83 01410  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>FIRST</b> <i>John</i> <b>MIDDLE</b> <i>DNI</i> <b>LAST</b> <i>STREET</i>   |  |  |  | 2a. DATE OF DEATH MONTH <i>1</i> DAY <i>27</i> YEAR <i>83</i>  |  | 2b. HOUR <i>4</i> <i>43</i> P.M.  |  |
| 3. SEX <i>M.</i>   | 4. RACE <i>B</i>   | 5. DATE OF BIRTH MONTH <i>5</i> DAY <i>21</i> YEAR <i>36</i>   |  | 6. AGE (IN YEARS, LAST BIRTHDAY) <i>46</i>   |  | IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i> IF UNDER 24 HRS. HOURS <i></i> MIN. <i></i>                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Balt.</i>   | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>City</i> MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH <i>City</i>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>U of M. P Hoop -</i> |  |  | 12a. USUAL OCCUPATION (TYPE OR GIVE MOST COMMON WORKING LIFE) <i>State Employee</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <i>Publishing</i>   |  |
| 13a. STATE <i>MD</i>   | 13b. COUNTY <i>BALTIMORE</i>   | 13c. CITY OR TOWN <i>BALTIMORE</i>   | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 13e. STREET ADDRESS <i>4402 Carlisle Rd -</i>  |  |   |  |
| 14. FATHER'S NAME <b>FIRST</b> <i>Clover</i> <b>MIDDLE</b> <i></i> <b>LAST</b> <i>STREET, SR.</i>  |  | 15. MOTHER'S MAIDEN NAME <b>FIRST</b> <i>AGNES C.</i> <b>MIDDLE</b> <i>Smith</i> <b>LAST</b> <i></i>   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <i>YES</i> (NO OR UNKNOWN) <i>1955-1958</i>   |  | 16b. SOCIAL SECURITY NO. <i>42152 4309</i>   |  | 17. INFORMANT <i>Inpatient Registration record</i> ADDRESS <i></i>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4310 Cardio Respiratory arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Intracerebral Intraventricular Hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Subarachnoid Hemorrhage</i>                                |  |  |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i></i>  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i> P.M. <i>19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from <i>1/25</i> 19 <i>83</i> , to <i>1/27</i> 19 <i>83</i> that (I) (we) last saw the deceased alive on <i>1/27</i> 19 <i>83</i> and that in (my) (our) opinion death occurred at the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE <i>[Signature]</i>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED <i>1/27/83</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>  |  | 23b. DATE <i>2-1-83</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY <i>Md. Mt. Crownsville</i>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Crownsville Md.</i>  |  |
| 24. FUNERAL DIRECTOR NAME <i>JAS. A. MORTON &amp; SONS</i> ADDRESS <i>1701 LAURENS</i>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <i>JAN 31 1983</i>   |  | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>   |  |

BP \_\_\_\_\_





*[Faint, mostly illegible handwritten text on lined paper, possibly a ledger or notebook page.]*

1st 4-Month Term 1901-1902  
2nd 4-Month Term 1902-1903  
3rd 4-Month Term 1903-1904  
4th 4-Month Term 1904-1905  
5th 4-Month Term 1905-1906  
6th 4-Month Term 1906-1907  
7th 4-Month Term 1907-1908  
8th 4-Month Term 1908-1909  
9th 4-Month Term 1909-1910  
10th 4-Month Term 1910-1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |   |   |   | 8 3 0 1 4 1 1   |  |
|---|---|---|---|---|--|
| 1 - STATE REGISTRAR   |   |   |   | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SUSAN</b> (nm) <b>STREET</b>   |   | 2a. DATE OF DEATH<br>1/22/1983  |   | 2b. TIME OF DEATH<br>12:25 PM   |  |
| 3. SEX<br><b>F FEMALE</b>   | 4. RACE<br><b>BLACK</b>   | 5. DATE OF BIRTH<br>8/13/25   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>57 yrs.  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NORTH CAROLINA</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> MD.                                    |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE CITY HOSP</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>DOMESTIC</b>             | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RESIDENCE</b>   |  |
| 13a. STATE<br><b>MD</b>   | 13b. COUNTY<br><b>BALTO</b>   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>117 East Ave. 21222</b>   |  |
| 14. FATHER'S NAME<br>FIRST <b>Wk</b> MIDDLE <b>Wk</b> LAST <b>Wk</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Wk</b> MIDDLE <b>Wk</b> LAST <b>Wk</b>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b> (IF YES, GIVE WAR OR DATES) <b>XX</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>216-28-1737</b>  |   | 17. INFORMANT<br><b>ANTHONY STREET H.H.B. 165</b><br><b>FT. BLISS, TEXAS 79916</b>                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4310</b> IMMEDIATE CAUSE (a) <b>Cessation of Heart &amp; Lung</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Massive Cerebral Hemorrhage</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertension</b>                       |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>30 1/2 hours</b><br><b>3 days</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>None</b>   |   |   |   |   |  |
| 19a. DATE OF OPERATION<br><b>1/22/83</b>  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b>Spontaneous hemorrhage</b> |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 22, 1983</b> to <b>Jan 22, 1983</b> , that (I) (we) last saw the deceased alive on <b>Jan 22, 1983</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |   |   |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |   | DEGREE<br><b>—</b>  |   | 22c. DATE SIGNED<br><b>1/22/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>De Silva</b>  |   | 22e. ADDRESS<br><b>550 N. Broadway Ave BALTO MD</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |   | 23b. DATE<br><b>1/25/1983</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. CALVARY CEMETERY</b>   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>GLEN BURNIE A.A.CO. MD.</b>  |   | 24. FUNERAL DIRECTOR<br><b>WALTER BROOKS BRADLEY INC., DUNDALK, MD. 21222</b>   |   |   |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 26 1983</b>   |   | REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |   |  |



1980 8 5 1944

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 4 1 2

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Joseph M. Strempek, Sr.  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 18, 1983    |  | 2b. HOUR<br>4:53 P.M.  |
| 3. SEX<br>MALE  | 4. RACE<br>WHITE   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 3 1906  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.                 |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD. |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED   | 12b. KIND OF BUSINESS OR INDUSTRY                          |  |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>BALTIMORE  | 13c. CITY OR TOWN<br>BALTIMORE                             | 13d. STREET ADDRESS<br>21224/ 634 SILVERWOOD AVE                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ANDREW STREMPER   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>UNKNOWN  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>312-01-0431A  |  | 17. INFORMANT<br>ADDRESS<br>HELEN STREMPER SISTER                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>4360 IMMEDIATE CAUSE (a) Cardiopulmonary Arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Cerebrovascular Accident<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>9 Days   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I (this hospital) attended the deceased from January 9, 1983, to January 18, 1983, that (we) lost saw the deceased alive on January 18, 1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (A (we) did not view the body after death.)   |  |   |  |  |  |
| 22b. SIGNATURE<br>Bayani B. Elma, M.D.  |  | DEGREE<br>MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>     |  | 22c. DATE SIGNED<br>1/18/83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Bayani B. Elma, M.D.   |  | 22e. ADDRESS<br>c/o Maryland General Hospital   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(BY WHOM)<br>BURIAL  |  | 23b. DATE<br>1-22-83  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>SAC. HEART MARY BALTIMORE MD.                  |  |
| 23d. NAME OF FUNERAL DIRECTOR<br>RAYMOND L. KACZOROWSKI   |  | 23e. ADDRESS<br>FLEET ST  |  | 23f. DATE RECEIVED BY REGISTRAR<br>JAN 25 1983                                       |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



1. NAME: [illegible]  
2. ADDRESS: [illegible]  
3. CITY: [illegible]  
4. STATE: [illegible]  
5. ZIP: [illegible]  
6. PHONE: [illegible]  
7. DATE: [illegible]  
8. SIGNATURE: [illegible]  
9. PRINTED NAME: [illegible]  
10. TITLE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |   |   |   | 8301413   |  |
|--|---|---|---|---|--|
| 1- FOR STATE REGISTRAR   |   |   |   | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WILLIAM J. STRICKER</b>  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1 30 83</b>                                  |   | 2b. HOUR<br><b>6:05 M</b>  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Aug. 29, 1916</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>North Charles General Hospital</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sales Clerk</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Hardware</b>   |
| 13a. STATE<br><b>Maryland</b>  |   | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>402 Radnor Rd. 21212</b>   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>William Joseph Stricker</b>  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Nellie Norton</b>                  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>215 01 3718</b>  | 17. INFORMANT ADDRESS<br><b>Mrs. A. Vernon Starnes, Same</b>                        |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>7866 Cardio-respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cachexia</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Lung Mass</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a  |   |   |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (s) (this hospital) attended the deceased from <b>1-27-83</b> to <b>1-30-83</b> , that (I) (we) lost saw the deceased alive on <b>1-30-83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.  |   |   |   |   |  |
| 22b. SIGNATURE<br><b>S. KULATHEN NGAM</b>  |   | DEGREE  |   | 22c. DATE SIGNED<br><b>1-30-83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>S. KULATHEN NGAM</b>   |   | 22e. ADDRESS<br><b>North Charles General Hosp. Balto MD</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>2/2/83</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>                          |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Balto., MD</b>   |
| 24. FUNERAL DIRECTOR NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b>  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 31 1983</b>                                 |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Coniff</b>  |
| 4905 York Road Balto., MD 21212  |   |   |   |   |  |



North Carolina State Hospital  
Raleigh, N.C.  
1963

William Joseph Sullivan  
1000 1st Ave. S.E.  
Atlanta, Ga. 30334

1963 JAN 31 1963  
J. G. Sullivan



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |  | REG. NO. 8301414  |  |   |  |
|---|--|---|--|---|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Laura E. Stubblebine</b>   |  |   |  |   |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>January 29, 1983</b>                                     |  | 2b. HOUR<br><b>12<sup>03</sup> A.M.</b> |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>04 19 11</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71 YRS</b>   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br><b>0 0</b>  |  | 7. IF UNDER 24 HRS. HOURS MIN.<br><b>0 0</b>  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNSYLVANIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                            |  |   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SEAMSTRESS</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CLOTHING</b>  |  |   |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |  |  |   |  |   |  |   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>---</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3708 McTAVISH AVENUE, 21229</b>   |  |   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>JOHN H. STUBBLEBINE</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>ELIZABETH C. SANDERS</b>   |  |  |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>166-16-6384</b>  |  | 17. INFORMANT ADDRESS<br><b>ALVERETTA M. DAVIS 3708 McTAVISH AVE.</b>                        |  |   |  |   |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carotid arrest</b><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic cardiovascular disease</b><br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes mellitus</b> |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>6 days</b><br><b>years</b> |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)  |  |  |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did not view the body after death.   |  |   |  |   |  |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE DEGREE<br><b>Gregory F. McAuliffe, M.D.</b>  |  |   |  |   |  |  |  |   |  | 22c. DATE SIGNED<br><b>1.29.83</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Gregory F. McAuliffe, M.D.</b>  |  |   |  |   |  |  |  |   |  | 22e. ADDRESS<br><b>ST. AGNES HOSPITAL, 900 S. CATON AVENUE</b>                                  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>02-01-83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OAKLAWN</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>WILKES BARRE LUZERNE PA.</b>                   |  |   |  |   |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.</b>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 31 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>   |  |   |  |   |  |

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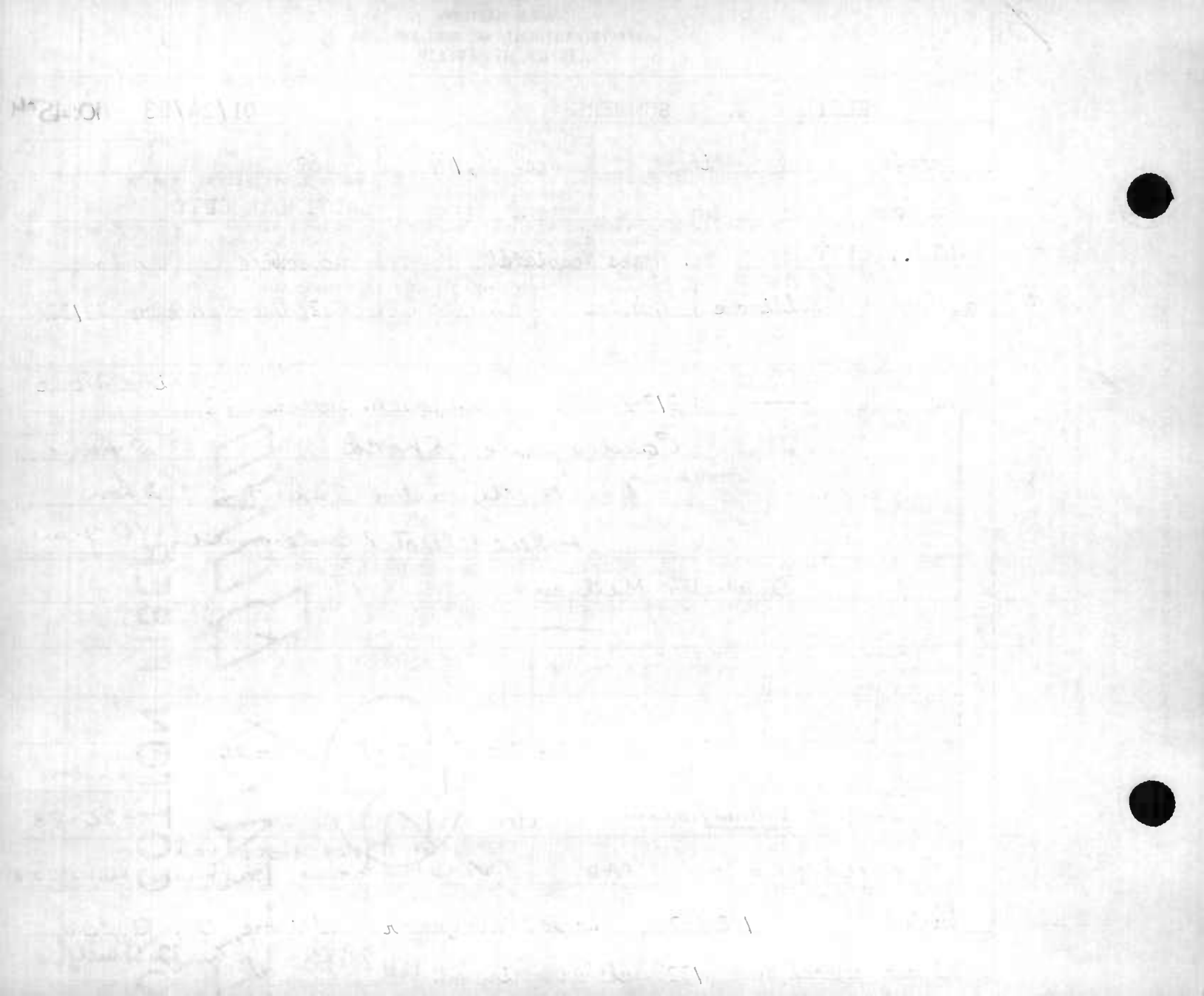
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  | REG. NO.   |  |
|--|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ELSIE A SUMMERS</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01/24/83</b>   |  | 2b. HOUR<br><b>10:45 AM</b>  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 05, 1899</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO., CITY</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>             |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Arbutus</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 13e. STREET ADDRESS<br><b>5629 Oregon Avenue 21227</b>           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Troeb</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mrs. Joan A. Summers</b>  |  | ADDRESS<br><b>4505 Ridge Avenue</b>  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-74-4567</b>   |  | 17. INFORMANT<br><b>Mrs. Joan A. Summers</b>   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4100 IMMEDIATE CAUSE (a) <b>Cardiogenic shock</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Atherosclerotic Cardiovascular</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hours</b><br><b>2 hours?</b><br><b>10 years.</b> |  |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Diabetes Mellitus.</b>   |  |   |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>None</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-20-</b> 19 <b>83</b> , to <b>1-24-</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>1-24-</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (I did) (did not) view the body after death.  |  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>George J. Vellaniharan</b>  |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1-24-83</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>G. VELLANIKARAN MD</b>   |  | 22e. ADDRESS<br><b>St. Agnes Hospital<br/>9005 Caton Avenue, Baltimore MD-21228</b>   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>burial</b>  |  | 23b. DATE<br><b>1/27/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore City, Maryland</b>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ambrose Funeral Home</b>  |  | ADDRESS<br><b>1328 Sulphur Spring Rd.</b>   |  | 25a. DATE REC'D BY REGISTRAR<br><b>JAN 26 1983</b>   |  |  |
|  |  |   |  | REGISTRAR'S SIGNATURE<br><b>John G. Conner</b>   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  | 8301416   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  |   |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>June L. Surwillo</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-8-83</b>  |  |  |  | 2b. HOUR<br><b>4:24 A.M.</b>  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 20 24</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>USA Oregon</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IS NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secours Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>unemployed</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>N/A</b>  |  |   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Balt City</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>215 S. Vincent St.</b> 21223   |  |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Roscoe - Wooley</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Juanita Howell Green</b>  |  |   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>220-76-7614</b>  |  | 17. INFORMANT ADDRESS<br><b>Shirley Keister 511 S. Collington Ave.</b>                          |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>hypoxic brain damage</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>metastatic carcinoma of lung</b><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><b>1629</b><br><b>diabetes mellitus, dehydration, malnutrition</b> |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>7 days</b><br><b>10 min.</b><br><b>1 1/2 years</b> |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>1-4</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br>21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>—</b>   |  |   |  |  |  |   |  |  |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>2000 W. BALTIMORE ST. BALT. 21223</b>  |  |   |  |   |  |  |  |   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>1-4</b> , 19 <b>83</b> , to <b>1-8</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>1-7</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Stephen R. Smith, MD</b>  |  |  |  |   |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1-8-83</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>STEPHEN R. SMITH, MD</b>   |  |  |  |   |  | 22e. ADDRESS<br><b>2000 W. BALTIMORE ST. BALT. 21223</b>  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Jan. 11, 1983</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crownsville Veterans</b>   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crownsville, Md.</b>  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Lilly &amp; Zeiler Inc. 1901 Eastern Ave. (21231)</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 10 1983</b>   |  |  |  |   |  |  |  |
|  |  |  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carmel</b>   |  |  |  |   |  |  |  |

*[Faint, illegible handwriting on lined paper]*

1211 S. Cedar St. (1111) 1211 S. Cedar St. (1111)  
1211 S. Cedar St. (1111) 1211 S. Cedar St. (1111)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |   |  | REG. NO.   |  |
|--|--|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  | 83 01417  |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HENRY SYKES</b>  |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR HOUR<br><b>01 11 83 6:30 P.M.</b>                |  |   |  |  |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>B</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>10 02 18</b>  |  | 6. AGE [IN YEARS LAST BIRTHDAY] YRS<br><b>64</b>                                  |  | IF UNDER 1 YEAR MONTHS DAYS<br><b></b>  |  | IF UNDER 24 HRS. HOURS MIN.<br><b></b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY MD.</b>                           |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIVERSITY</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b></b>          |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b></b> |  |  |
| 13a. STATE<br><b>md</b>  |  |   |  |   |  | 13b. COUNTY<br><b>BALTO</b>   |  | 13c. CITY OR TOWN<br><b>BALTO</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Willie Sykes</b>   |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Willie Mae Freeman</b>           |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>228-10-1057</b>  |  | 17. INFORMANT ADDRESS<br><b>Cornelia Sykes 765 N. Grantley St.</b>  |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>GENERALIZED BLEEDING</b><br><b>4429</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>DISSECTING ANEURYSM AORTA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>HYPERTENSION</b> |  |   |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>RENAL FAILURE</b>  |  |   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>1-6-83</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>DISSECTING ANEURYSM</b>  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)<br><b></b>  |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b></b>  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b></b>   |  |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-6-83</b> to <b>1-11-83</b> , that (I) (we) last saw the deceased alive on <b>1-10-83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Sergio Tavares, M.D.</b>  |  | DEGREE<br><b></b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  |   |  | 22c. DATE SIGNED<br><b>1-11-83</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SERGIO TAVARES</b>   |  |   |  | 22e. ADDRESS<br><b>University Hospital</b>  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>1/15/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Family Plot Cem.</b>   |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Norfolk Va.</b>   |  |  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>Wm. C. March F/H Inc. 1101 E. North Avenue</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 12 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Cahill</b>                               |  |   |  |  |  |

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CHIEFLY



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 4 1 8

FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CHARLOTTE H. TALBOTT</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01 28 83</b>  |  | 2b. HOUR<br><b>P.M.</b>  |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>09 26 1896</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86 YRS.</b>                              | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW YORK</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.              |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3538 HICKORY AVENUE, 21211</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b>            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>                                |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |   |  |  |
| 13a. STATE<br><b>MARYLAND</b>  | 13b. COUNTY<br><b>---</b>  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>3538 HICKORY AVENUE, 21211</b>                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>EMIL ENGELSKIRCH</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SELMA UNKNOWN</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215-22-5955</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>OTTO H. ENGELSKIRCH 307 THIRD AVE., 21227</b>   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ASCVD</b><br><b>4029</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>A</b>   |
| MEDICAL CERTIFICATION  |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 19 67</b> to <b>JAN 19 83</b> , that (I) (we) lost<br>saw the deceased alive on <b>Dec 8 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Sheldon Goldgeier M.D.</b>  |  | DEGREE  |   | 22c. DATE SIGNED<br><b>1/29/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SHELDON GOLDGEIER, M.D.</b>  |  | 22e. ADDRESS<br><b>711 W. 40th STREET</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  | 23b. DATE<br><b>01-31-83</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MEADOWRIDGE MEM. PK.</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ELKRIDGE HOWARD MARYLAND</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>  |  | ADDRESS<br><b>4107 WILKENS AVE.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 31 1983</b>                            | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canine</b>  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



11/11/64

DO NOT WRITE IN THESE SPACES



RELEASED ON APPROVAL BY THE MEDICAL EXAMINER'S OFFICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and a death certificate must be completed.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO. 83 01419   |  |  |  |   |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST<br>JULIA  |  | MIDDLE<br>ANN  |  | LAST<br>TASCO   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>01 08 83   |  | 2b. HOUR<br>2:19A <sub>M</sub>                |  |
| 3. SEX<br>Female  |  | 4. RACE<br>BLACK  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>JULY 22, 1900   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BROOKNEAL, VA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTIMORE CITY HOSPITAL |  |  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>OWN HOME |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE COUNTY<br>XXREINX MD. ---   |  |   |  | 13b. CITY OR TOWN<br>BALTIMORE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1816 N. MILTON AVE. 21213   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Daniel --- Wood  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>ARDELIA --- WOOD   |  |   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO                         |  |   |  |
| 16a. SOCIAL SECURITY NO.<br>224-16-6419   |  |   |  | 17. INFORMANT ADDRESS<br>CORRINE FORBES, 1816 N. MILTON AVE. BALTIMORE, MD.  |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypertension</u><br>8938<br>DUE TO, OR AS A CONSEQUENCE OF <u>Sepsis:</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>DUE TO, OR AS A CONSEQUENCE OF <u>Burns</u><br>(c) _____ |  |   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Mark trauma</u> <u>Pneumonia</u> <u>Trauma</u>  |  |   |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 12 26 1984   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><u>MARCH 1st 1984</u>  |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)<br><u>Home</u>   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><u>1816 N. Milton Ave. Baltimore MD</u>  |  |   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/26/83</u> to <u>1/11/84</u> , and that in (my) (our) opinion, death was caused by the cause and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><u>Jeffrey Peters</u>   |  |   |  | DEGREE<br>CERTIFICATION APPROVED BY MEDICAL EXAMINER<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL STAFF DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><u>1/8/83</u>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Jeffrey Peters</u>  |  |   |  | 22e. ADDRESS<br><u>610 N. Broadway</u>   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>1/11/83  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>OAK GROVE CHURCH CEM.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>STERLING LOUDOUN VA.                                 |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>J. BERKLEY GREEN, 721 ELDEN ST., HERNDON, VA  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 17 1983   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Connel</u>  |  |   |  |

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NOTES ON THE HISTORY OF THE MOUNTAIN

THE MOUNTAIN IS A VERY OLD ONE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR

2. DECEASED NAME (TYPE OR PRINT)

3. SEX

4. RACE

5. DATE OF BIRTH

6. AGE (IN YEARS LAST BIRTHDAY)

7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

8. CITIZEN OF WHAT COUNTRY?

9. BALTIMORE CITY OR COUNTY OF DEATH

10. CITY OR TOWN OF DEATH

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE

13b. COUNTY

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS?

13e. STREET ADDRESS

14. FATHER'S NAME

15. MOTHER'S MAIDEN NAME

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

19c. AUTOPSY?

19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. TIME OF INJURY

20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21a. INJURY OCCURRED

21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21c. LOCATION

22a. I certify that this hospital attended the deceased from 1/16/83 to 1/16/83, that (we) last saw the deceased alive on 1/15/83, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)

22b. SIGNATURE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION

24. FUNERAL DIRECTOR

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

MEDICAL CERTIFICATION

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 4 2 0

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST<br>ARTHUR (KIRKBRIDE) TAYLOR JR  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>1 16 83   |  | 2b. HOUR<br>3 A.M.  |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>11/16/1912   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 yrs. YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>C.P.A.  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>ACCOUNTING   |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>---   |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET ADDRESS<br>123 W. 29th St.  |  | 13f. CITY OR TOWN<br>BALTIMORE   |  | 13g. STATE<br>MARYLAND  |  | 13h. ZIP CODE<br>21218  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ARTHUR K. TAYLOR, SR.   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>REBECCA ROBB  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217.03.3940                          |  |
| 17. INFORMANT<br>ANN T. VANIK   |  | 18. ADDRESS<br>3521 N. FURNACE RD.<br>JARRETTSVILLE, MD.   |  | 19. CITY OR TOWN<br>BALTIMORE   |  | 20. STATE<br>MD.  |  |
| 21. ZIP CODE<br>21084   |  | 22. DATE OF DEATH<br>1/16/83   |  | 23. HOUR<br>3 A.M.  |  | 24. PLACE OF DEATH<br>BALTIMORE   |  |
| 25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  | 26. IMMEDIATE CAUSE (a)<br>cardio respiratory arrest   |  | 27. DUE TO, OR AS A CONSEQUENCE OF (b)<br>anoxic coma   |  | 28. DUE TO, OR AS A CONSEQUENCE OF (c)<br>myocardial infarct                                    |  |
| 29. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST   |  | 30. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Diabetes Mellitus, 1/2 CVA, pneumonia |  | 31. DATE OF OPERATION<br>1/5/83   |  | 32. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>amputation of gangrenous foot                |  |
| 33. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 34. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 35. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>                                 |  | 36. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                       |  |
| 37. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  | 38. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                    |  | 39. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 40. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 41. I certify that this hospital attended the deceased from 1/16/83 to 1/16/83, that (we) last saw the deceased alive on 1/15/83, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.) |  | 42. SIGNATURE<br>D M Daffney   |  | 43. DATE SIGNED<br>1/16/83  |  | 44. PHYSICIAN'S NAME (TYPE OR PRINT)<br>D M Daffney   |  |
| 45. ADDRESS<br>Union Memorial Hospital Balto Md   |  | 46. BURIAL, CREMATION, REMOVAL<br>CREMATION  |  | 47. DATE<br>1/17/1983   |  | 48. NAME OF CEMETERY OR CREMATORY<br>GREEN MOUNT CREMATORY                                      |  |
| 49. LOCATION<br>BALTIMORE   |  | 50. STATE<br>MARYLAND  |  | 51. FUNERAL DIRECTOR<br>WALTER BROOKS BRADLEY INC., BALTO. MD. 21222  |  | 52. DATE REC'D. BY REGISTRAR<br>JAN 17 1983   |  |
| 53. REGISTRAR'S SIGNATURE<br>John J. Conner   |  | 54. DATE OF DEATH<br>1/16/83   |  | 55. HOUR<br>3 A.M.  |  | 56. PLACE OF DEATH<br>BALTIMORE   |  |

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Handwritten text on the left side, possibly a date or reference number.

Handwritten text in the upper middle section.



Main body of handwritten text, consisting of several lines of cursive script.

Second section of handwritten text, continuing the narrative or list.

Final section of handwritten text at the bottom of the page.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8301421

1 - STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>ARTHUR A TAYLOR                |  |   | 2c. DATE OF DEATH MONTH DAY YEAR<br>JAN 21 83   |  | 2b. HOUR<br>330 PM  |
| 3. SEX<br>MALE  | 4. RACE<br>BLACK   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 1 44   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>38 YRS.                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD MARYLAND                                | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD. |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIV. OF MARYLAND |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MAINTENANCE                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>HOSPITAL                   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |   |   |  |   |
| 13a. STATE<br>MARYLAND  | 13b. COUNTY<br>BALTIMORE   | 13c. CITY OR TOWN<br>BALTIMORE  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>502 DUNDAL RD 21229                 |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>EDINBURD TAYLOR                               |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ELIZABETH COOPER   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) YES                |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>VIET NAM 218-42-7870   |   | 17. INFORMATION ADDRESS<br>HOSPITAL CHART                  |   |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>2001 IMMEDIATE CAUSE (a) PULMONARY HEMORRHAGE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ASPERGILLUS INFECTION<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) LYMPHOBLASTIC LYMPHOMA |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
|---|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from JUN 9 19 81, to JAN 21 19 83, that (I) (we) lost<br>saw the deceased alive on JAN 21 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE<br>Michael Hamilton MD  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>1/21/83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>D. MICHAEL HAMILTON   |  | 22e. ADDRESS<br>UNIV. OF MARYLAND CANCER CRT<br>22 S. GREEN ST. BALT MD  |  |  |  |

|  |                      |   |  |
|--|----------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL           | 23b. DATE<br>1-26-83 | 23c. NAME OF CEMETERY OR CREMATORY<br>M/T CHILVERLY CEM | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore AA Co Md |
| 24. FUNERAL DIRECTOR<br>NAME<br>Joseph H. Ross 7222 W. NORTH AVE |                      | 25a. DATE REC'D. BY REGISTRAR<br>JAN 31 1983            |  |

25b. REGISTRAR'S SIGNATURE  
John J. Smith

na



1A191

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 4 2 2

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |   |  |   |
|---|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Charles Daniel Taylor  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1-30-83                              |  | 2b. HOUR<br>12 <sup>20</sup> A.M.                               |
| 3. SEX<br>male ♂  | 4. RACE<br>Cauc   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 5 07   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospitals |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Steel                      |
| 13a. STATE<br>Maryland  |   |   | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Douglas Taylor  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth Taylor           |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>212-10-6055   |   | 17. INFORMANT<br>ADDRESS<br>Elizabeth Taylor 6004 Eastern Ave. 21224                 |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u><br>1619<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>airway obstruction</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <u>lung cancer</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>minutes<br>2 months<br>6 months |   |   |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>chronic renal failure</u>   |   |   |   |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |   |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-25-82</u> , 19____, to <u>1-30-83</u> , 19____, that (I) (we) lost saw the deceased alive on <u>1-29-83</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |   |   |   |  |   |
| 22b. SIGNATURE<br>W. Russell  |   | DEGREE<br>MD  |   | 22c. DATE SIGNED<br>1-30-83  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>William M. Russell   |   | 22e. ADDRESS<br>1739E Balt. City Hosp   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Entombment   |   | 23b. DATE<br>2-2-83   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn Cemetery                              |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Eastwood, Balto. Co., Md.   |   |   |   |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Charles S. Zeiler & Son Inc. 6224 Eastern Av.   |   | ADDRESS   |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 1 1983  |   |
|   |   |   |   | 25b. REGISTRAR'S SIGNATURE<br>John J. Carney   |   |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 3.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)                     |  | 2a. DATE OF DEATH  |  | 2b. HOUR   |  |
|   |  | Clarence Taylor Sr                                      |  | January 9, 1983  |  | M  |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE   |  |
| Male  |  | White   |  | October 24, 1902   |  | 80   |  |
| 7a. BIRTHPLACE  |  | 7b. CITIZEN OF WHAT COUNTRY?                            |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| Maryland  |  | U.S.A.  |  |  |  | Baltimore City   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Baltimore   |  | Hamilton Nursing Center                                 |  | Retired Div. Gen   |  | Motors   |  |
| 13a. USUAL RESIDENCE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. STREET ADDRESS  |  |
| Maryland  |  |   |  | Baltimore  |  | 3808 Echodale Ave 21206  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME                                |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |  | 16b. SOCIAL SECURITY NO.                                       |  |
| Henry Taylor  |  | Catherine Mills   |  | No   |  | 195-05-5384  |  |
| 17. INFORMANT   |  | ADDRESS   |  | 18. CAUSE OF DEATH   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| Mr Clarence Taylor Jr 26 Tenbury Rd   |  | Lutherville, Md   |  | PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 3320<br>DUE TO, OR AS A CONSEQUENCE OF (b) Acute M. I., ASCVD<br>DUE TO, OR AS A CONSEQUENCE OF (c) with brady arrhythmia<br>Parkinson's disease |  | approx. 4 hrs  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED        |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21b. TIME OF INJURY                                     |  | 21c. HOW INJURY OCCURRED   |  |  |  |
| (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | HOUR A.M. MONTH DAY YEAR                                |  | (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY                                    |  | 21f. LOCATION  |  |  |  |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>   |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)          |  | STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/25, 1978, to 1/9, 1983, that (I) (we) lost saw the deceased olive on 12/31, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  | 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED   |  |
|   |  | I.W. Fromm M.D.   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  | 1/10/83  |  |
| 23a. BURIAL, CREMATION, REMOVAL   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  |
| Burial  |  | 1/12/83   |  | Dulaney Valley   |  | Baltimore, Maryland  |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR                           |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
| Leonard J Ruck Inc. Baltimore, Maryland   |  | JAN 11 1983   |  | J. J. Carick   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  | 83 01424      |           |                                       |                  |  |  |
|--|--|---|--|---|--|--|--|--|--|---------------|-----------|---------------------------------------|------------------|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.  |  |   |  |  |  |  |  |               |           |                                       |                  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>GILBERT  |  | MIDDLE<br>TAYLOR.   |  | LAST<br>TAYLOR.  |  | 2a. DATE OF DEATH                              |  | MONTH<br>1    | DAY<br>13 | YEAR<br>83                            | 2b. HOUR<br>3:00 | MIN.<br>PM   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH  |  | MONTH<br>11  |  | DAY<br>9                                       |  | YEAR<br>07    |           | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 |                  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS<br>HOURS<br>MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>WEST VIRGINIA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. City MD.  |  |  |  |               |           |                                       |                  |  |  |
| 10. CITY OR TOWN OF DEATH<br>City  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Lutheran Hosp. |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MACHINIST   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>BETH STEEL  |  |  |  |               |           |                                       |                  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md   |  | 13b. COUNTY<br>Balto  |  | 13c. CITY OR TOWN<br>Balto  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  | 13e. STREET ADDRESS<br>1213 Light Street 21230 |  |               |           |                                       |                  |  |  |
| 14. FATHER'S NAME  |  | FIRST<br>JAMES  |  | MIDDLE<br>TAYLOR  |  | LAST<br>TAYLOR   |  | 15. MOTHER'S MAIDEN NAME                       |  | FIRST<br>LOTA |           | MIDDLE<br>WEESE                       |                  | LAST<br>TAYLOR                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>232100361   |  | 17. INFORMATION<br>ADDRESS<br>506 S. MARQUERITE TAYLOR MADIERA ST   |  |  |  |  |  |               |           |                                       |                  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>4860 IMMEDIATE CAUSE (a) Respiratory failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Pneumonia -<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                 |  |   |  |   |  |  |  |  |  |               |           |                                       |                  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br>COPD - Dementia.  |  |   |  |   |  |  |  |  |  |               |           |                                       |                  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |               |           |                                       |                  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |               |           |                                       |                  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |               |           |                                       |                  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/26, 1982, to 1/13, 1983, that (I) (we) lost<br>saw the deceased alive on 1/13, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |  |  |               |           |                                       |                  |  |  |
| 22b. SIGNATURE<br>BILH T Duong   |  | DEGREE<br>M.D.  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br>1-13-83  |  |  |  |               |           |                                       |                  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BILH THUY DUONG   |  | 22e. ADDRESS<br>Lutheran Hospital   |  |   |  |  |  |  |  |               |           |                                       |                  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>1-18-83  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>OAKLAND CEM   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO MD   |  |  |  |               |           |                                       |                  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>JOHN M. WEBER & SONS INC   |  | ADDRESS<br>401 S. ST. CHESTER   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 18 1983  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Conner   |  |  |  |               |           |                                       |                  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   | 8 3 0 1 4 2 5   |   |  |   |                                   |   |
|--|--|---|--|---|---|---|--|---|-----------------------------------|---|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   |  |   | REG. NO.  |   |  |   |                                   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Louis TAYLOR</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 4, 1983</b> |   |  | 2b. HOUR<br><b>4:42<sup>P</sup><sub>M</sub></b>   |                                   |   |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8/6/11</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |                                   |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |   |                                   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY   |                                   |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>21217 1919 Eutaw Pl. Apt. 3D</b>  |                                   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Taytor</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Joanna Taylor</b>   |   |   |  |   |                                   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>219-01-7368</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Annie Montgomery 1919 Eutaw Pl 3D</b>                            |  |   |                                   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the right Lung, with extensive involvement</b><br><b>1629</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br><b>of the thoracic wall and diaphragm.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Pulmonary thrombo-embolus of inferior bifurcation of</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |   |   |  |   |                                   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.<br><b>pulmonary artery with partial occlusion.</b>   |  |   |  |   |   |   |  |   |                                   |   |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |   |                                   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |                                   |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 3, 19 83</b> , to <b>January 4, 19 83</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>January 4, 19 83</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.   |  |   |  |   |   |   |  |   |                                   |   |
| 22b. SIGNATURE<br><b>JA Nkwanyuo</b>   |  |   |  |   | DEGREE<br><b>MD</b>   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1/5/83</b> |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Joseph Nkwanyuo, M.D.</b>  |  |   |  |   | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>          |   |  |   |                                   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/8/83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt Calvary Cem.</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brooklyn AA Md.</b>                            |  |   |                                   |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Chas.A.Rice FSPA 1300 Eutaw Pl.</b>   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 11 1983</b>           |   |  |   |                                   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b> |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 (Highly Recommended) should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |   |  | 8 3 0 1 4 2 6   |  |  |  |
|--|--|--|--|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  |   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MILORED Grant TAYLOR</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>01-20-83</b>   |  |   |  | 2b. HOUR<br><b>10:20</b> P.M.   |  |  |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>06-10-10</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS<br>HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S. C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore city</b> MD.                               |  |   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>North Charles General Hosp</b> |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)          |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE<br><b>Md</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1807 N. Gay Street 21213</b>                    |  |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ed Wilson</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nora James</b>  |  |   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>  |  | 17. INFORMANT ADDRESS<br><b>Charles Wilson 1807 N. Gay Street</b>                               |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4360</b> IMMEDIATE CAUSE (a) <b>SEPTICEMIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PNEUMONIA, URINARY TRACT INFECTION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CEREBRO VASCULAR ACCIDENT</b> |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>01-06-83</b> , 19 <b>83</b> , to <b>01-20-83</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>01-20-83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Cesar Gamboa MD</b>   |  |  |  |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>1-20-83</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CESAR GAMBOA MD</b>  |  |  |  |   |  | 22e. ADDRESS<br><b>U. CHARLES GENERAL HOSPITAL</b>  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  |  | 23b. DATE<br><b>1/26/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Eastview Mem Park</b>                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md</b>         |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>William C. March F/H 1101 E. North Ave</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 24 1983</b>   |  | 25. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                           |  |   |  |  |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3, BETAIN, PAGE 3, FOR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17  
(VR A15 ME (1))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

|  |         |  |  |  |  |  |  |   |  |  |  |                            |  |      |  |          |  |
|--|---------|--|--|--|--|--|--|---|--|--|--|----------------------------|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE KNOWN<br>OF DEATH  |  | MONTH                                      |  | DAY                        |  | YEAR |  | 2b. HOUR |  |
| NATHANIEL  |         | TAYLOR   |  |  |  |  |  | 1-25-83   |  |  |  |                            |  |      |  |          |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)  |  | IF UNDER 1 YR.   |  | IF UNDER 24 HRS.  |  | 7c. DATE<br>PRONOUNCED<br>DEAD             |  | MONTH                      |  | DAY  |  | YEAR     |  |
| Male   | Black   | 9 28 34  |  | 48 YRS.  |  |  |  |   |  | 1-25-83                                    |  |                            |  |      |  | 3:34     |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED   |  | NEVER MARRIED  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |                            |  |      |  |          |  |
| md.  |         | U.S.   |  | WIDOWED  |  | DIVORCED   |  | Baltimore City  |  |  |  |                            |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY                     |  |   |  |  |  |                            |  |      |  |          |  |
| Baltimore  |         | 1634 N. Gilmore Street   |  | Disabled   |  |  |  |   |  |  |  |                            |  |      |  |          |  |
| 13a. STATE   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?                                 |  | 13e. STREET ADDRESS   |  |  |  |                            |  |      |  |          |  |
| md.  |         | Balt.  |  | Balt.  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 1634 N. Gilmore St.   |  |  |  |                            |  |      |  | 21217    |  |
| 14. FATHER'S NAME  |         | MIDDLE   |  | LAST   |  | 15. MOTHER'S MAIDEN NAME                                 |  | MIDDLE  |  | LAST                                       |  |                            |  |      |  |          |  |
| Era  |         | Taylor   |  |  |  | Mary   |  | Williams  |  |  |  |                            |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS  |  |   |  |  |  |                            |  |      |  |          |  |
| No   |         | 215-30-4995  |  | Shirley Taylor   |  | 1634 N. Gilmore St.                                      |  |   |  |  |  |                            |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |  |  |  |  |  |  |   |  |  |  |                            |  |      |  |          |  |
| PART I DEATH WAS CAUSED BY:  |         |  |  |  |  |  |  |   |  |  |  |                            |  |      |  |          |  |
| 5771 IMMEDIATE CAUSE (a) chronic pancreatitis  |         |  |  |  |  |  |  |   |  |  |  |                            |  |      |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |  |  |  |  |   |  |  |  |                            |  |      |  |          |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  |         |  |  |  |  |  |  |   |  |  |  |                            |  |      |  |          |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |  |  |  |  |   |  |  |  |                            |  |      |  |          |  |
| (c)  |         |  |  |  |  |  |  |   |  |  |  |                            |  |      |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |         |  |  |  |  |  |  |   |  |  |  |                            |  |      |  |          |  |
| 19a. DATE OF OPERATION   |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                |  |  |  |   |  |  |  |                            |  |      |  |          |  |
|  |         |  |  |  |  |  |  |   |  |  |  |                            |  |      |  |          |  |
| 20. AUTOPSY?   |         |  |  |  |  |  |  |   |  |  |  |                            |  |      |  |          |  |
| YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |         |  |  |  |  |  |  |   |  |  |  |                            |  |      |  |          |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19       |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |  |                            |  |      |  |          |  |
|  |         |  |  |  |  |  |  |   |  |  |  |                            |  |      |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |         |  |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |  |  |                            |  |      |  |          |  |
|  |         |  |  |  |  |  |  |   |  |  |  |                            |  |      |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |  |  |  |  |  |  |   |  |  |  |                            |  |      |  |          |  |
| ACTUAL SIGNATURE <i>Margarita A. Korell</i> TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 1-29-83   |         |  |  |  |  |  |  |   |  |  |  |                            |  |      |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn Street  |         |  |  |  |  |  |  |   |  |  |  |                            |  |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |         |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY                       |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |                            |  |      |  |          |  |
| Burial   |         |  |  | 11/30/83   |  | Mt Zion Cemetery   |  |   |  | Balt. md.                                  |  |                            |  |      |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME Jeff Miller Funeral Services ADDRESS 319 Shroeder St  |         |  |  |  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR              |  | 25b. REGISTRAR'S SIGNATURE |  |      |  |          |  |
|  |         |  |  |  |  |  |  |   |  | JAN 31 1983                                |  | <i>John J. Carver</i>      |  |      |  |          |  |

WILSON, J. H. 1987. The effects of temperature and salinity on the growth and survival of the bay anchovy, *Anchoa mitchilli*, in the laboratory. *Journal of Experimental Marine Biology and Ecology* 110:111-124.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 3 0 1 4 2 8  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |                      |  |   |  |  |   |   |   |  |
|---|----------------------|--|---|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>OLIVER C. TAYLOR</b>   |                      |  | 2a. DATE OF DEATH MONTH <b>01</b> DAY <b>21</b> YEAR <b>83</b>      |  |  | 2b. HOUR <b>7:44</b> AM   |   |   |  |
| 3. SEX <b>Male</b>  | 4. RACE <b>Black</b> | 5. DATE OF BIRTH MONTH <b>March</b> DAY <b>4</b> YEAR <b>1892</b>  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS.                      |  | 7. UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>  |   |   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>British W.I.</b>   |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore, City</b> MD.                                   |   |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mercy Hospital</b> |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Ret. Stewart</b>         |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Coast Guard</b> |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Maryland</b> 13c. COUNTY <b>Baltimore</b> 13d. CITY OR TOWN <b>Baltimore</b>   |                      |  |   | 13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13f. STREET ADDRESS <b>21201 524 N. Charles Street</b>  |   |   |  |
| 14. FATHER'S NAME FIRST <b>Irvin</b> MIDDLE <b>Taylor</b> LAST <b>Taylor</b>  |                      |  |   | 15. MOTHER'S MAIDEN NAME FIRST <b>?</b> MIDDLE <b>?</b> LAST <b>?</b>  |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>  |                      | 16b. SOCIAL SECURITY NO. <b>WWII-Korean-078-22-5749-</b>   |   | 17. INFORMANT ADDRESS <b>21201 Nettie H. Taylor-524 N. Charles St</b>  |  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4100 IMMEDIATE CAUSE (a) Ventricular arrhythmia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>  |                      |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH              |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>  |                      |  |   |  |  |   |   |   |  |
| 19a. DATE OF OPERATION  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>         |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                    |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/21</b> , 19 <b>83</b> , to <b>1/21</b> , 19 <b>83</b> that (I) (we) saw the deceased alive on <b>1/21</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                      |  |   |  |  |   |   |   |  |
| 22b. SIGNATURE <b>Weisinger MD</b> DEGREE   |                      |  |   |  |  | 22c. DATE SIGNED <b>1/21/83</b>   |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR FRANK MORRIS</b>  |                      |  |   |  |  | 22e. ADDRESS <b>Mercy Hospital</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (S) <b>Burial</b>   |                      |  | 23b. DATE <b>1/25/1983</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Crownsville, Vet. Cem- Crownsville, AA Co. Md.</b> |   | 23d. LOCATION CITY OR TOWN COUNTY STATE                   |   |  |
| 24. FUNERAL DIRECTOR NAME <b>Herbert E. Miller - 3035 W. North Ave.</b> ADDRESS   |                      |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 28 1983</b> REGISTRAR'S SIGNATURE <b>John J. [Signature]</b> |   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

SECRET



CONFIDENTIAL

20X6/COIT



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and it may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove co-kan papers. Pages 1 and 2 should be filed with the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

DHMH-16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |  |   |  |   | 8301429 |
|--|--|---|--|---|--|--|---|--|---|---------|
| 1. FOR STATE REGISTRAR   |  |   |  |   | REG. NO.   |  |   |  |   |         |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <del>ELIA</del> <sup>FIRST</sup> VIVA <sup>MIDDLE</sup> JANE <sup>LAST</sup> TAYLOR  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 28 83                                 |  |   | 2b. HOUR<br>7:49 M   |   |         |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 31 1992   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>90 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |   |         |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>North Carolina  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |   |  |   |         |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SAINT AGNES HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOMEMAKER        |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>--  |   |         |
| 13a. STATE<br>MD   |  |   |  |   | 13b. COUNTY<br>Baltimore City  |  | 13c. CITY OR TOWN<br>City   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |         |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Flemon Cooper Edwards  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Nancy -- Spurlin              |  |   |  |   |         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  |   |  |   | 16b. SOCIAL SECURITY NO.<br>213-74-8188  |  | 17. INFORMANT<br>ADDRESS<br>Edith, Taylor<br>DAUGHTER Same as above |  |   |         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <u>Acute Severe Cardio Vascular dis</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <u>Age</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Immediate</u> |  |   |  |   |  |  |   |  |   |         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:<br><u>Multiple trauma, Illusion from</u>   |  |   |  |   |  |  |   |  |   |         |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |         |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |   |         |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |   |         |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/10</u> , 19 <u>83</u> , to <u>11/28</u> , 19 <u>83</u> , that (he) (we) last saw the deceased alive on <u>11/27/83</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.      |  |   |  |   |  |  |   |  |   |         |
| 22b. SIGNATURE<br><u>Cliff Ratliff</u>   |  |   |  |   | DEGREE<br><u>MD</u>  |  | 22c. DATE SIGNED<br><u>11/29/83</u>                                 |  |   |         |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>CLIFF RATLIFF, MD</u>  |  |   |  |   | 22e. ADDRESS<br><u>5770 WESTVIEW MALL CATIMASH, MD</u>                         |  |   |  |   |         |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   | 23b. DATE<br>Feb. 1, 1983  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Carmel Cemetery                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Emmorton Harford Md.  |  |   |         |
| 24. FUNERAL DIRECTOR<br>NAME<br>Howard K. McComas III, Abingdon, Md. 21009   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 31 1983                                   |  | 25b. REGISTRAR'S SIGNATURE<br><u>James J. Conner</u>                |  |   |         |

MEDICAL CERTIFICATION

50297 1 28 82



THE STATE OF NEW YORK  
IN SENATE  
JANUARY 28, 1982

REPORT OF THE  
COMMISSIONER OF THE  
DEPARTMENT OF ENVIRONMENTAL CONSERVATION  
ON THE  
STATE OF THE ENVIRONMENT  
FOR THE YEAR 1981

ALBANY: STATE OF NEW YORK  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8301430

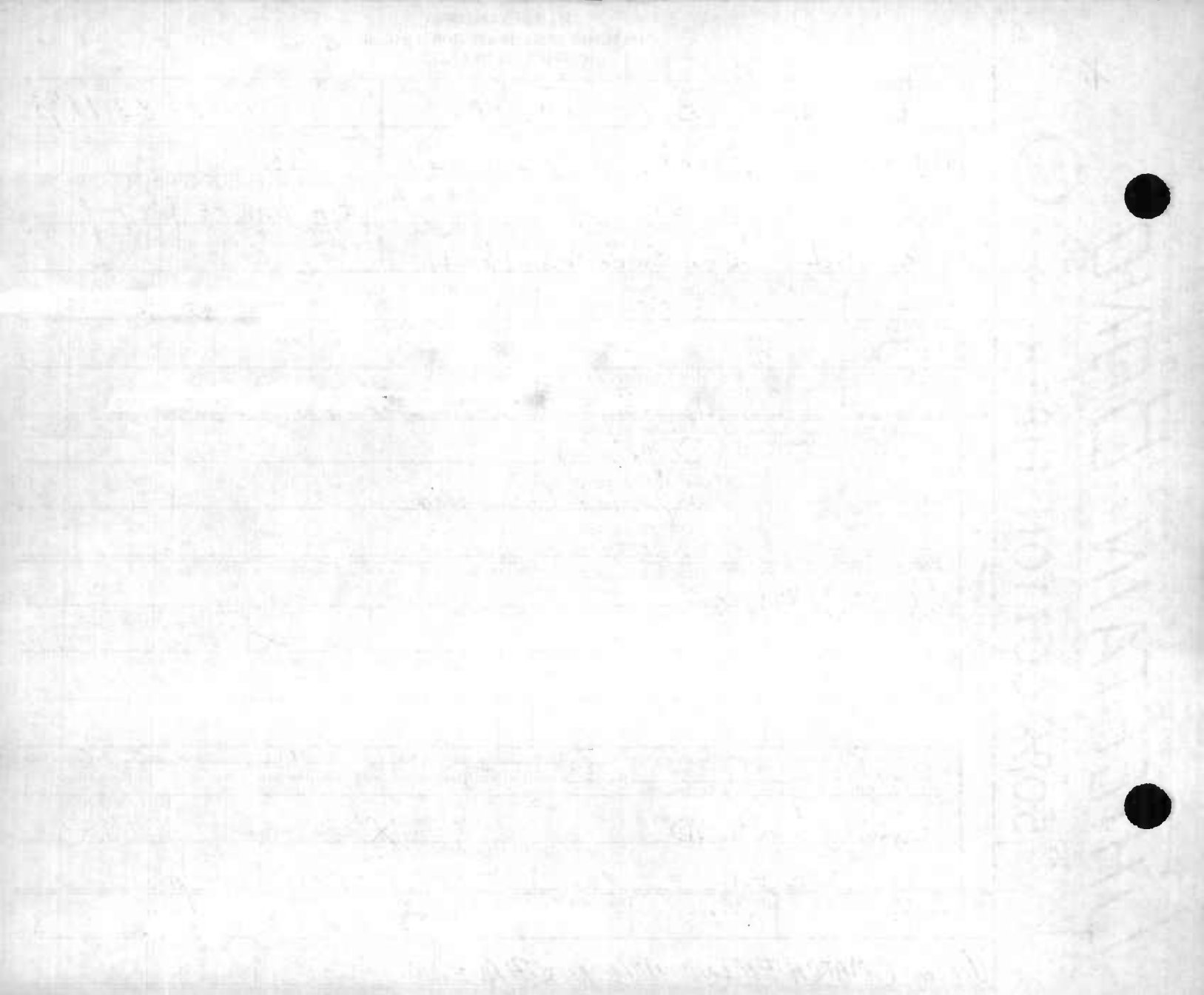
REG. NO.

|  |  |  |  |  |  |   |   |
|--|--|--|--|--|--|---|---|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>William B. TAYLOR   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>1-1-83   |  | 2b. HOUR<br>11 <sup>05</sup> PM   |   |
| 3. SEX<br>Male   |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>8-8-47  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>35 YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.   |  | MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |   |
| 10. CITY OR TOWN OF DEATH<br>Balt., Md.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Bon Secours Hosp. |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William Taylor, Sr.   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Marie Wonson   |  | 13e. STREET ADDRESS<br>2647 Lorette Avenue 00000   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>N/A  |  | 17. INFORMANT ADDRESS<br>Phillis Scriber 1718 E. Lamont Avenue   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Aspiration Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Hepaticellular Carcinoma</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Chronic Hepatitis B</u> |  |  |  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)<br>P.M. 19   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)   |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (a) (this hospital) attended the deceased from <u>July</u> , 19 <u>83</u> , to <u>1/1</u> , 19 <u>83</u> , that (b) (we) last saw the deceased alive on <u>1/1</u> , 19 <u>83</u> , and that (c) (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (d) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |   |
| 22b. SIGNATURE<br><u>Charles G. Coulter MD</u>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>     |  | 22c. DATE SIGNED<br>1/2/83  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Coulter   |  |  |  | 22e. ADDRESS<br>Bon Secours Hospital   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>1/5/83  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Pk.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arbutus Md  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>William C. MARCH F&H INC.  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>4/1983  |  |   |   |
| ADDRESS<br>1101 E. NORTH AVE   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Canine   |  |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |                                   |  |  |
|---|--|--|--|--|--|--|-----------------------------------|--|--|
| 1. FOR STATE REGISTRAR  |  | 83 01431   |  |  |  |  |                                   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 2a. DATE OF DEATH  |  |  |  | 2b. HOUR   |                                   |  |  |
| FIRST MIDDLE LAST<br>JOHN T. THAXTON  |  | MONTH DAY YEAR<br>1 31 83  |  |  |  | 3:40 P.M.  |                                   |  |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR  |                                   | IF UNDER 24 HRS.   |  |
| Male  | Black  | MONTH DAY YEAR<br>11 19 07   |  | 75 YRS.  |  | MONTHS DAYS  |                                   | HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |                                   |  |  |
| VA  | USA  |  |  | Baltimore City MD.   |  |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| Baltimore   | Baltimore City Hospital  |  |  |  |  |  |                                   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?   |                                   |  |  |
| MD  |  |  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                   |  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 13e. STREET ADDRESS  |  |  |                                   |  |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST  |  | 2740 The Alameda 21218   |  |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |  |                                   |  |  |
| No  |  | 213-07-4164  |  | Mary Curry 2740 The Alameda  |  |  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR ARREST</u><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>SQUAMOUS CELL LUNG CANCER</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Approximate interval between onset and death: <u>7 months</u>           |  |  |  |  |  |  |                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |  |                                   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |                                   |  |  |
|   |  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  |  |                                   |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION  |  |  |                                   |  |  |
| WHILE <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | STREET CITY OR TOWN COUNTY STATE   |  |  |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/17/83</u> , 19 <u>83</u> , to <u>1/31/83</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>1/31</u> , 19 <u>83</u> , and that it is (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |                                   |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                   | 22c. DATE SIGNED   |  |
| <u>Robert A. Weisberg MD</u>  |  |  |  |  |  |  |                                   | <u>1/31/83</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |  |  |                                   |  |  |
| <u>ROBERT A. WEISBERG MD</u>  |  |  |  | <u>BALTIMORE CITY HOSPITAL</u>   |  |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |                                   | COUNTY STATE   |  |
| Burial  |  | 2/5/83   |  | Mt. Auburn Cem.  |  | Baltimore  |                                   | MD   |  |
| 24. FUNERAL DIRECTOR  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |                                   |  |  |
| NAME ADDRESS<br>Wm. C. March F/H 1101 E. North Ave.   |  |  |  | FEB 1 1983   |  | <u>John J. Conner</u>  |                                   |  |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 01432

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |                           |   |
|--|--|--|--|---|---------------------------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MARIE E. THELEN</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 17, 1983</b> |   | 2b. HOUR<br><b>3:00AM</b> |   |
| SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 26 09</b>   |                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Home Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |                           | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                           | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Raymond John Rose</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lillie McCoy</b>   |  |   |                           |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218-01-0921D</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Raymond J. Thelen, 2343 Searles Road<br/>Baltimore, Md. 21222</b>  |                           |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4292</b> IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>ARTERIOSCLEROSIS CARDIOVASCULAR DISEASE</b> YEARS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>2 DAYS</b> |  |  |  |   |                           |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>DIABETES MELLITUS, CONGESTIVE HEART FAILURE</b>   |  |  |  |   |                           |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                           |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                           |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                           |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>DEC. 28, 1982</b> to <b>JAN. 17, 1983</b> , that (I) (we) saw the deceased alive on <b>JAN. 17, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |                           |   |
| 22b. SIGNATURE<br><i>Paul Gormley</i>  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>1/17/83</b>  |                           |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PAUL GORMLEY, M.D.</b>   |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION<br/>100 N. BROADWAY, BALTIMORE, MD. 21203</b>   |  |   |                           |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1-20-83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart of Jesus</b>  |                           |   |
| 24. FUNERAL DIRECTOR<br><b>Nicholas T. Matthews, 3021 Eastern Avenue<br/>Baltimore, Md.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Baltimore Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 19 1983</b>   |                           |   |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Joan J. Carver</i>   |                           |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



Handwritten text at the bottom left: "Handwritten" and "ORIGINAL" (written upside down).

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 1 4 3 3

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |                      |  |   |  |  |  |                                |  |                                |  |
|---|--|----------------------|--|---|--|--|--|--------------------------------|--|--------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Albert A Thomas</b>      |  |                      | 2a. DATE OF DEATH MONTH DAY YEAR <b>01-25-83</b>   |   |  | 2b. HOUR <b>10 A</b> M   |  |                                |  |                                |  |
| 3. SEX <b>MALE</b>  |  | 4. RACE <b>BLACK</b> |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>05 12 09</b> |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.   |  | 7. IF UNDER 1 YEAR MONTHS DAYS |  | 7. IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna</b>          |  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD. |                                |  |
| 10. CITY OR TOWN OF DEATH <b>Balto.</b>                         |  |                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran Hospital of MD.</b> |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>   |  |                                | 12b. KIND OF BUSINESS OR INDUSTRY                              |                                |  |
| 13a. STATE <b>Md.</b>   |  |                      | 13b. COUNTY <b>BALTIMORE</b>   |   |  | 13c. CITY OR TOWN <b>BALTIMORE</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |                                | 13d. STREET ADDRESS <b>21216 802 WHITMORE AVE</b>              |                                |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Earnest Thomas</b>       |  |                      | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Minnie</b>   |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  |                                | 16b. SOCIAL SECURITY NO.                                       |                                |  |
| 17. INFORMANT ADDRESS <b>Ronald Thomas 2710 Baker St. 21215</b> |  |                      |  |   |  |  |  |                                |  |                                |  |

|  |  |  |  |
|--|--|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY Failure</b><br><b>1539</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Disseminated CARCINOMA of Colon</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <b>Murkum</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|--|--|--|--|

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION <b>1-6-83, 1-18-83</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Intestinal obstruction, prolonged distention</b> |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <b>12-25-82</b> to <b>1-25-83</b> , that (b) (we) lost <b>1-25-83</b> above, the deceased alive on <b>1-25-83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated. |  |  |  |  |  |  |  |
| 22b. SIGNATURE <b>Kwang N. Kim</b>  |  | DEGREE <b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <b>1-25-83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KWANG NAM KIM</b>  |  | 22e. ADDRESS <b>730 Ashburton Ave 21216</b>  |  |  |  |  |  |

|  |  |                          |  |  |  |  |  |
|--|--|--------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>            |  | 23b. DATE <b>1/29/83</b> |  | 23c. NAME OF CEMETERY OR CREMATORY <b>St. Luke Cem.</b>                                      |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Reisterstown, Md.</b> |  |
| 24. FUNERAL DIRECTOR <b>Leroy O. Dyett 4600 Liberty Hgts. Ave.</b> |  |                          |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 27 1983</b> REGISTRAR'S SIGNATURE <b>John J. Carver</b> |  |  |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



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Handwritten text at the bottom center, possibly a date or reference number.

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Handwritten text in the lower left quadrant.

Handwritten text in the middle right section.

Handwritten text in the middle left section.

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Handwritten text in the upper left section.

Small handwritten word or initials.

Small handwritten word or initials.

Small handwritten word or initials.

Small handwritten word or initials.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |         |                   |  |  |                         |  |  |                |                  |  |   |  |          |  |
|--|--|---------|-------------------|--|--|-------------------------|--|--|----------------|------------------|--|---|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |         | FIRST MIDDLE LAST |  |  | 2a. DATE KNOWN OF DEATH |  |  | MONTH DAY YEAR |                  |  | 2b. HOUR  |  |          |  |
| John Jerome Thomas   |  |         |                   |  |  | 1 21 19 83              |  |  |                |                  |  | M   |  |          |  |
| 3. SEX   |  | 4. RACE |                   | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)       |  | IF UNDER 1 YR.   |                | IF UNDER 24 HRS. |  | 2c. DATE PRONOUNCED DEAD  |  | 2d. HOUR |  |
| Male   |  | W       |                   | 5 23 24  |  | 58 YRS.                 |  |  |                |                  |  | 1 23 19 83  |  | 4:15 P M |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |         |                   | 7b. CITIZEN OF WHAT COUNTRY?   |  |                         |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                |                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |          |  |
| Md.  |  |         |                   | U.S.A.   |  |                         |  |  |                |                  |  | Baltimore City, MD.   |  |          |  |
| 10. CITY OR TOWN OF DEATH  |  |         |                   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION   |  |                         |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |                |                  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |          |  |
| Baltimore  |  |         |                   | 411 S. Augusta Avenue  |  |                         |  | Retired-Westinghouse   |                |                  |  |   |  |          |  |
| 13a. STATE   |  |         |                   | 13b. COUNTY  |  |                         |  | 13c. CITY OR TOWN  |                |                  |  | 13d. INSIDE CITY LIMITS?  |  |          |  |
| Md.  |  |         |                   |  |  |                         |  | Balto.   |                |                  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| 14. FATHER'S NAME  |  |         |                   | 15. MOTHER'S MAIDEN NAME   |  |                         |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |                |                  |  | 16b. SOCIAL SECURITY NO.  |  |          |  |
| UNKNOWN  |  |         |                   | Constance ?  |  |                         |  | Yes <input type="checkbox"/> No <input type="checkbox"/>   |                |                  |  | W.W. II 219-18-6598   |  |          |  |
| 17. INFORMANT  |  |         |                   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |                         |  | 19a. DATE OF OPERATION   |                |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                   |  |          |  |
| 424 S. Augusta Ave., Balto., Md. #21229  |  |         |                   | PART I DEATH WAS CAUSED BY:<br>5728 IMMEDIATE CAUSE (a) Hepatic failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                         |  |  |                |                  |  |   |  |          |  |
| 19c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |         |                   | 20. AUTOPSY?   |  |                         |  | 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                      |                |                  |  | 21b. TIME OF INJURY   |  |          |  |
|  |  |         |                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                         |  |  |                |                  |  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                 |  |          |  |
| 21c. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |         |                   | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                         |  | 21e. LOCATION  |                |                  |  | 21f. LOCATION   |  |          |  |
|  |  |         |                   |  |  |                         |  | STREET CITY OR TOWN COUNTY STATE   |                |                  |  | STREET CITY OR TOWN COUNTY STATE                                    |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |         |                   | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion                     |  |                         |  | TITLE (SPECIFY)  |                |                  |  | DATE SIGNED   |  |          |  |
| ACTUAL SIGNATURE   |  |         |                   | M.D. Deputy Chief  |  |                         |  | MEDICAL EXAMINER   |                |                  |  | 1/24/83   |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |         |                   | Thomas D. Smith, M.D.  |  |                         |  | ADDRESS  |                |                  |  | 111 Penn St. Balto., MD.  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |         |                   | 23b. DATE  |  |                         |  | 23c. NAME OF CEMETERY OR CREMATORY   |                |                  |  | 23d. LOCATION   |  |          |  |
| Burial   |  |         |                   | 1-27-83  |  |                         |  | Meadowridge Cem.   |                |                  |  | Howard Co., Md.   |  |          |  |
| 24. FUNERAL DIRECTOR   |  |         |                   | 25a. DATE REC'D. BY REGISTRAR  |  |                         |  | 25b. REGISTRAR'S SIGNATURE   |                |                  |  |   |  |          |  |
| G. Truman Schwab 3512 Frederick Ave. #21229  |  |         |                   | JAN 25 1983  |  |                         |  | John J. Connel   |                |                  |  |   |  |          |  |

|   |   |   |   |   |   |   |   |   |    |
|---|---|---|---|---|---|---|---|---|----|
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

83 01435

|   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MARY MIDDLE R LAST THOMAS      |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 22nd 1983                          |   | 2b. HOUR<br>M   |
| 3. SEX<br>Female  | 4. RACE<br>Black  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>September 18, 1923  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania                   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Kedwick Nursing Home |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired Clerk |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Int. Commission            |
| 13a. STATE<br>Maryland  |   | 13b. COUNTY<br>P.G.   | 13c. CITY OR TOWN<br>Temple Hills   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>2114 Keating St. 20748                   |
| 14. FATHER'S NAME<br>FIRST Presley A. MIDDLE LAST Sluby                     |   | 15. MOTHER'S MAIDEN NAME<br>FIRST Rebecca MIDDLE LAST Bush  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>N/A |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>186-20-8214  |   | 17. INFORMANT<br>ADDRESS<br>James H. Thomas 2114 Keating St.                                    |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

4360

IMMEDIATE CAUSE (a) Bronchopneumonia

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) multiple Cerebral Vascular Accidents

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

1 wk

2 yrs

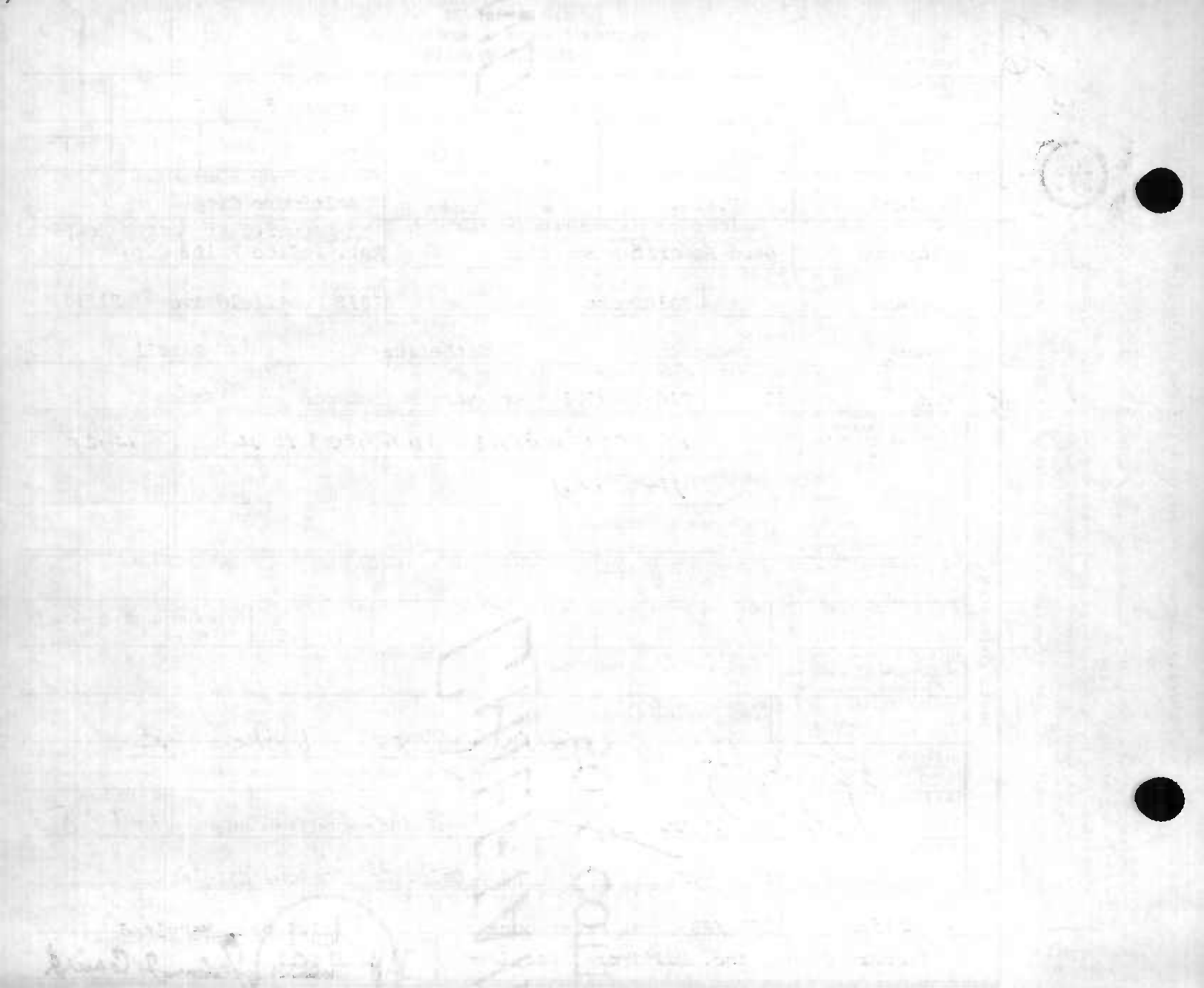
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-8</u> , 19 <u>82</u> , to <u>1-22</u> , 19 <u>83</u> , that (I) (we) lost<br>saw the deceased alive on <u>1-21</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Dr. H. H. Wilson Jr. MD</u>  |  | DEGREE<br>MD   |  | 22c. DATE SIGNED<br>1-22-83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |

|  |                       |   |  |
|--|-----------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial | 23b. DATE<br>01-26-83 | 23c. NAME OF CEMETERY OR CREMATORY<br>Forest Hills Cemetery | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Clinton, Md. |
| 24. FUNERAL DIRECTOR<br>NAME<br>Robert G. Mason        |                       | 25a. DATE REC'D BY REGISTRAR<br>JAN 27 1983                 |  |
| ADDRESS<br>1661 Good Hope Rd.                          |                       | 25b. REGISTRAR'S SIGNATURE<br>John J. Cahill                |  |







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 4/82  
(VRA 15, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |              |   | 8 3 0 1 4 3 7  |   |   |
|---|--|---|--------------|---|--|---|---|
| 1 - STATE REGISTRAR   |  |   |              |   | REG. NO.   |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   | FIRST<br>LEE | MIDDLE<br>E.  | LAST<br>THOMPSON   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 10 83  | 2b. HOUR<br>7:55 A.M.   |
| 3. SEX<br>MALE  |  | 4. RACE<br>Black  |              | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 5 37  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>45 YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |              | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Md. Cancer center |              |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |   |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY   |              | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>LEE E. Thompson, Sr.  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Edith Jordan   |              | 13e. STREET ADDRESS<br>911 W. Lexington St. 21228   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE YEAR OR DATES)<br>yes Vietnam  |  | 16b. SOCIAL SECURITY NO.  |              | 17. INFORMANT<br>Dobra Thompson 3405 Clifton Ave.   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1640 CARDIO-RESPIRATORY Arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) MENINGO-ENCEPHALITIS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) METASTATIC THYMOMA             |  |   |              |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |              |   |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |              |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |              | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/23/82 to 1-10-83, that (I) (we) last saw the deceased alive on 1-8-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |              |   |  |   |   |
| 22b. SIGNATURE<br>A. Sergio Cassanego MD  |  |   |              | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>1-10-83   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A. Sergio Cassanego  |  |   |              | 22e. ADDRESS<br>22 S. Greene St. - Balto - 21201  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>1/13/83  |              | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. Veterans Cem.   |  | 23d. LOCATION<br>Crownsville Md.  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Chas. H. Powell Fitt  |  |   |              | 25a. DATE REC'D. BY REGISTRAR<br>JAN 12 1983  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Connel  |   |

M

CHILD WASH

COLO COLTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and page 3 should be attached.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 3 0 1 4 3 8   |  |  |  |
|--|--|---|--|---|--|--|--|
| FOR<br>STATE<br>REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>BARBARA S THOUMAIA</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>January 02-1983</b>  |  |  |  |
| 3 SEX<br><b>FEMALE</b>   |  | 4 RACE<br><b>WHITE</b>  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>8 15 1914</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS. MONTHS DAYS<br><b>4 18</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD USA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>   |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>WYMAN PARK HEALTH SYSTEM, Inc</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>                                       |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HENRY RUPPALT</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ELIZABETH Telljohann</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213 05 8031</b>   |  |
| 17. INFORMANT ADDRESS<br><b>Armen H. Thoumaian 3614 Keene Avenue 21214</b>   |  |   |  | 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Refractory Congestive Heart Failure + Acute Renal Failure</b><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MASSIVE MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Cancer of the Colon</b>   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>NOV 22 1982</b> to <b>JANUARY 02 1983</b> , that (I) (we) last saw the deceased alive on <b>January 02 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Mirtha L Balcazar, MD</b>   |  |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>Jan 02-83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Mirtha L Balcazar, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>WYMAN PARK HEALTH SYSTEM, Inc</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>Jan 3 1983</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore</b>   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc.</b>  |  |   |  | ADDRESS<br><b>Baltimore, Maryland</b>   |  | 25a. DATE RECEIVED BY REGISTRAR<br><b>JAN 3 1983</b>   |  |
| 25b. SIGNATURE<br><b>John J. Ruck</b>  |  |   |  | 25c. SIGNATURE  |  |  |  |



1917-18

1918-19

1919-20

1920-21

1921-22

1922-23

1923-24

1924-25

1925-26

1926-27

1927-28

1928-29

1929-30

1930-31

1931-32

1932-33

1933-34

1934-35

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |  |  |  |  | 8 3 0 1 4 3 9   |  |
|--|--|--|--|--|--|--|--|--|--|---|--|
| FOR<br>STATE<br>REGISTRAR  |  |  |  |  |  |  |  |  |  | CERTIFICATE OF DEATH  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH   |  |
| FIRST MIDDLE LAST  |  |  |  |  |  |  |  |  |  | MONTH DAY YEAR  |  |
| PERCY TILGHMAN   |  |  |  |  |  |  |  |  |  | January 11, 1983  |  |
| 3. SEX   |  |  |  |  |  |  |  |  |  | 7b. HOUR P M  |  |
| MALE   |  |  |  |  |  |  |  |  |  | 3:48  |  |
| 4. RACE  |  |  |  |  |  |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |
| BLACK  |  |  |  |  |  |  |  |  |  | 80  |  |
| 5. DATE OF BIRTH   |  |  |  |  |  |  |  |  |  | 8. YRS.   |  |
| MONTH DAY YEAR   |  |  |  |  |  |  |  |  |  | MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| MARYLAND   |  |  |  |  |  |  |  |  |  | Baltimore City MD.  |  |
| 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION                       |  |
| US   |  |  |  |  |  |  |  |  |  | Maryland General Hospital   |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION   |  |
| Baltimore  |  |  |  |  |  |  |  |  |  | WAITER  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| Maryland General Hospital  |  |  |  |  |  |  |  |  |  |   |  |
| 13a. INSIDE CITY LIMITS?   |  |  |  |  |  |  |  |  |  | 13b. STREET ADDRESS   |  |
| YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 2417 W. LAFAYETTE ST. 21216   |  |
| 14. FATHER'S NAME  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |
| FIRST MIDDLE LAST  |  |  |  |  |  |  |  |  |  | FIRST MIDDLE LAST   |  |
| JAMES TILGHMAN   |  |  |  |  |  |  |  |  |  | UNKNOWN   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |  |  |  |  |  |  |  |  |  | 17. INFORMANT   |  |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES)  |  |  |  |  |  |  |  |  |  | ADDRESS   |  |
| NO   |  |  |  |  |  |  |  |  |  | GRACE SANCHEZ 2417 W. LAFAYETTE AVE.  |  |
| 16b. SOCIAL SECURITY NO.   |  |  |  |  |  |  |  |  |  | 17. ADDRESS   |  |
| 215-03-1351  |  |  |  |  |  |  |  |  |  | 2417 W. LAFAYETTE AVE.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                  |  |
| IMMEDIATE CAUSE (a) <u>Pneumonia</u>   |  |  |  |  |  |  |  |  |  | 26 48 Hrs   |  |
| DUE TO, OR AS A CONSEQUENCE OF, (b) <u>H/O Urinary tract inf</u>   |  |  |  |  |  |  |  |  |  | Sep 82  |  |
| DUE TO, OR AS A CONSEQUENCE OF, (c) <u>Diabetes Mellitus</u>   |  |  |  |  |  |  |  |  |  | YRS.  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |  |  |  |  |  |  |  |   |  |
| <u>ASCIT</u>   |  |  |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY?   |  |
|  |  |  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                |  |
|  |  |  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  |  |  |  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED   |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)           |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/9 1976 to 1/11 1983, that (I) (we) lost saw the deceased alive on 1/9 1983 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED  |  |
| 22b. SIGNATURE   |  |  |  |  |  |  |  |  |  | 22d. ADDRESS  |  |
| Amatun N Naeem MD  |  |  |  |  |  |  |  |  |  | 501 Dolphin St B-112 MD   |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |  |  |  |  |  |  | 22f. ADDRESS  |  |
| AMATUN N NAEEM   |  |  |  |  |  |  |  |  |  | 501 Dolphin St B-112 MD   |  |
| 23a. BURIAL, CREMATION, REMOVAL  |  |  |  |  |  |  |  |  |  | 23b. DATE   |  |
| BURIAL   |  |  |  |  |  |  |  |  |  | 1-15-83   |  |
| 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  |  |  |  |  |  | 23d. LOCATION   |  |
| MD. NAT. MEM. PK.  |  |  |  |  |  |  |  |  |  | LAUREL MARYLAND   |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  |
| E.L. PHILLIPS 1721 N. MONROE ST.   |  |  |  |  |  |  |  |  |  | JAN 20 1983   |  |
| 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |  |  |  |  |   |  |
| [Signature]  |  |  |  |  |  |  |  |  |  |   |  |



January 11, 1953

PEACE

University of California

San Diego

San Diego

CHIT

CHIT

CHIT

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |                  |  |   |  |  |  |  |  |                                  |  |   |  |  |  |   |  |  |  |                             |  |  |  |
|--|--|------------------|--|---|--|--|--|--|--|----------------------------------|--|---|--|--|--|---|--|--|--|-----------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                  |  | FIRST<br>James  |  |  |  | MIDDLE<br>E.   |  |                                  |  | LAST<br>Tillett<br>(Tillett) Jr.  |  |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br>1 14 1983 |  |  |  | 2b. HOUR<br>M<br>7:43P<br>M |  |  |  |
| 3. SEX<br>male   |  | 4. RACE<br>Black |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 5 52  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>31 YRS. |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS   |  | 8. IF UNDER 24 HRS.<br>HOURS MIN |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>1 14 1983   |  |  |  | 7d. HOUR<br>M   |  |  |  |                             |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD                                      |  |  |  |   |  |  |  |                             |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1214 N. Caroline Street |  |  |  |  |  |                                  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |                             |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                  |  |   |  |  |  |  |  |                                  |  | 13a. STREET ADDRESS<br>1214 N. Caroline St. 21213   |  |  |  |   |  |  |  |                             |  |  |  |
| 13a. STATE<br>Maryland   |  |                  |  | 13b. COUNTY   |  |  |  | 13c. CITY OR TOWN<br>Baltimore   |  |                                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |   |  |  |  |                             |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James E. Tillett, Sr.  |  |                  |  |   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Oletha Marshall   |  |                                  |  |   |  |  |  |   |  |  |  |                             |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |                  |  | (IF YES, GIVE WAR OR DATES)   |  |  |  | 16b. SOCIAL SECURITY NO.<br>214-56-5578  |  |                                  |  | 17. INFORMANT<br>James E. Tillett, Sr.  |  |  |  | ADDRESS<br>628 Jasper St.   |  |  |  |                             |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>2500 IMMEDIATE CAUSE (a) Diabetes with complications<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |                  |  |   |  |  |  |  |  |                                  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |  |  |                             |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |                  |  |   |  |  |  |  |  |                                  |  |   |  |  |  |   |  |  |  |                             |  |  |  |
| 19a. DATE OF OPERATION   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  |                                  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |  |  |   |  |  |  |                             |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |                                  |  |   |  |  |  |   |  |  |  |                             |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |                                  |  |   |  |  |  |   |  |  |  |                             |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                  |  |   |  |  |  |  |  |                                  |  |   |  |  |  |   |  |  |  |                             |  |  |  |
| ACTUAL SIGNATURE<br>Thomas D. Smith  |  |                  |  | TITLE (SPECIFY)<br>M.D. Deputy Chief  |  |  |  | MEDICAL EXAMINER   |  |                                  |  | DATE SIGNED<br>1/15/83  |  |  |  |   |  |  |  |                             |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Thomas D. Smith, M.D.  |  |                  |  | ADDRESS<br>111 Penn St. Balto., MD.   |  |  |  |  |  |                                  |  |   |  |  |  |   |  |  |  |                             |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL  |  |                  |  | 23b. DATE<br>1/20/83  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mount Calvary Cem.   |  |                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. Md.                                 |  |  |  |   |  |  |  |                             |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm.C. March F/H Inc.   |  |                  |  |   |  |  |  | ADDRESS<br>1101 b. North Ave.  |  |                                  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 17 1983  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Carver                        |  |  |  |                             |  |  |  |



RECEIVED

NOV 11 1964



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

DHMH-16 50M 7/77  
(VRA 15 (4))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |   |  |  |  | 8 3 0 1 4 4 1                                |  |  |  |
|---|--|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |  |  |   |  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Archie</b><br>(TINDALL) (ARCHIE) Tindal  |  |   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 17 83  |  |  |  | 2b. HOUR<br>1205 A.M.                        |  |  |  |
| 3 SEX<br>Male   |  | 4 RACE<br>Black   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 8 08   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.                |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S. Carolina  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                       |  |  |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Johns Hopkins Hospital |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1706 N. Washington St. 21213  |  |  |  |  |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore   |  |   |  |  |  |  |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Tindal   |  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Josephine Canty  |  |   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-07-1817  |  | 17. INFORMANT ADDRESS<br>Watchulla E. Tindal 1706 N. Washington St.  |  |   |  |  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute MI with cardiopulmonary arrest</b><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic CHF, ventricular aneurysm secondary to old MI.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ASCVD with angina, peripheral vascular disease, and chronic CHF</b><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) _____  |  |   |  |  |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Charles S. Ansell MD  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  |   |  | 22c. DATE SIGNED<br>1/17/83  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Charles S. Ansell MD   |  |   |  | 22e. ADDRESS<br>611 Brk Ave. Balto. MD 21201   |  |   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>1/22/83  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD                                      |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H Inc. 1101 E. North Avenue  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 18 1983   |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Baker   |  |  |  |  |  |  |  |

MEDICAL CERTIFICATION

